

**THE PUBLIC HEALTH NURSE  
AND HER PATIENT**

THE  
*Public Health Nurse  
and Her Patient*

*RUTH GILBERT, R.N.*

*Coordinator, Course for Mental Hygiene Consultants  
and Professor of Nursing Education  
Teachers College, Columbia University*

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*Published for*  
THE COMMONWEALTH FUND  
*by*  
HARVARD UNIVERSITY PRESS  
*Cambridge, Massachusetts*  
1961

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SECOND EDITION, REVISED AND ENLARGED  
COPYRIGHT, 1951, BY  
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FOURTH PRINTING

DISTRIBUTED IN GREAT BRITAIN BY  
OXFORD UNIVERSITY PRESS  
LONDON

PUBLISHED FOR  
THE COMMONWEALTH FUND  
BY  
HARVARD UNIVERSITY PRESS  
79 GARDEN STREET  
CAMBRIDGE 38, MASS.

*Printed in the United States of America*

## Acknowledgments

IT IS A PLEASURE and a satisfaction to acknowledge indebtedness to the nursing profession for the experiences that underlie this book. The original edition was based on an index of more than a thousand patients and situations that had been discussed by nurses with the author. The intervening years have brought continued companionship with nurses, a further opportunity to compare notes with them, and, more recently, have given the author the opportunity to continue to learn through teaching in an academic environment that encourages free and productive work. She is grateful for the organized strength of her profession as a whole and to the many nurses who, as individuals and in groups, have stimulated her, worked along with her, and on occasion have borne with her.

She also thanks her fellow psychiatric social workers and the psychologists and psychiatrists with whom she has worked and learned, and who have been interested in the work of nurses. Among the latter the author wishes to mention especially Dr. Paul V. Lemkau, Associate Professor, School of Hygiene and Public Health, The Johns Hopkins University, who has been a leader in visualizing and putting into words the role of the public health nurse in mental hygiene; and Dr. George S. Stevenson, Medical Director of The National Association for Mental Health, who has given generously of his time and his creative ability to the work for the Mental Hygiene Committee of the National Organization for Public Health Nursing since that Committee's inception.

How does one properly thank the men and women who have had vast and useful ideas, and rich clinical experience, and who on this basis have written fine books that help us? The author can only thank them by quoting or referring to many of them in the following pages.

R. G.

*Stony Creek, Connecticut*  
*April 1951*

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## Chapter 1

# MENTAL HYGIENE IN PUBLIC HEALTH NURSING

### »» INTRODUCTION ««

If one talked with nurses in various parts of this country eleven years ago, when the first edition of this book was written, one had the feeling they wished—and sometimes expected—that mental hygiene could offer the nursing profession a form of Ten Commandments, easily applicable to crowded days and large case loads. Our case loads still are large and our days busy, whether we work in city districts or in rural areas. However, although we may sometimes long for someone to tell us what to say or what to “do next,” as a professional group we seem to have passed the stage when we, like many others, expected mental hygiene to give us blanket definitions as to “right” and “wrong” procedure in work with people. Today there is a growing recognition that mental hygiene offers no such short cut but rather an informed, deliberate, observant method of working, a habit of stopping to think what the behavior of the patient and others may mean in relation to a situation and how the nurse herself relates to it.\* Nurses ask themselves questions such as these: What do I know that seems valid in situations of this kind and in this specific situation? How best can I put to use what I know? How can I learn more?

No easy substitute exists for the processes which lead to such increased understanding. Mental hygiene can never be a soothing contribution to professional equipment and point of view. It is too stimulating for that. One cannot escape from the constant need to weigh circumstances and behavior once one has accepted this way of working. Furthermore, it may be unsettling to find that outgrown attitudes or beliefs must be left behind as understanding of oneself and of others grows.

\* “Behavior” is used in this book as meaning *the entire response or adjustment pattern of the individual.* “Situation” is used somewhat loosely to include the factors which exist outside the individuals involved and the internal factors as far as we know them—the personality make-up which results both from inborn tendencies and from past external factors. Their interaction in a given instance constitutes the “situation.”

To prevent a disease, two things are required: knowledge and organization. As for the first, we need to know the cause of the disease and its means of transmission, and we should have information about the number of susceptibles in the community. Armed with such facts, we begin a preventive campaign, if we have the organization to apply them. Let us, for a moment, look at mental and emotional disturbances as though they were pandemic, which I believe in truth they are. Can we put our finger on the cause of them? No, not in any simple way. But can we say that the tubercle bacillus alone causes tuberculosis? If that were true, all of us would be sufferers from these maladies. Even if we do not know their exact cause, what we can do is to describe the setting out of which these mental and emotional disorders arise. About that we have a good deal of information."

If professional groups can become more coordinated in such a preventive effort, it should be possible to reach vastly more people than has been true in the past and to reach them earlier and in a way that has more meaning for them.

The attempt to reach people "early"—to help them retain their equilibrium rather than struggle to regain it—has two different meanings, both useful to us. It refers in the first place to the chronological age of the individual and suggests that the child, or more specifically the newborn infant in his family, is as near to a beginning point as we can find. It is true that earlier than infancy is the prenatal period and, earlier than that, the make-up and experience of parents as adults and, still earlier, as children. So that one can go in a circle if one wishes to do so. Yet it is possible to see that each infant is a new individual in a new situation.

In the second place, every new experience at any time of an individual's life is "early" in his assimilation of that experience. The individual will react to the new experience somewhat as he has previously reacted to other experiences. But the new experience is a variable—it is not just like previous experiences—and the setting in which the new experience takes place can be a variable also, with potentials for health. For example, an adult patient coming to a cancer clinic for the first time can have a relatively helpful experience there, no matter what the diagnosis, if we see to it that this happens.

Dr. Paul V. Lemkau reminds us that the human personality is built upon a base or around a core of constitutional endowment, though this, too, can be influenced to some extent by

environment. The personality of the individual grows by means of many successive and interlocking life experiences. He calls these experiences "building stones" and says they can be relatively strong or weak, built in well or ill, and that the structure is never finished.<sup>62, 63</sup>

The International Preparatory Commission of the International Congress on Mental Health of 1948 emphasizes that the individual is capable of change throughout life, though it must be remembered that either progress or deterioration is implied.<sup>64</sup> The Commission then sharpens up this general statement by pointing out that there is in each person an orderly sequence of growth, development, maturation, and decline. We can, then, adapt our way of working with individuals and our teaching to their phase of development, and at each phase, try to guard against introducing experience known to be harmful. For example, study indicates that separation from the mother is very difficult for a baby during the last part of the first year of life and the early part of the second year. If hospitalization is needed but can be postponed beyond the time when a mother person is the only object on which the baby can fasten his feelings, we take this into consideration in helping to plan elective surgery.

The accent is on the best use of the immediate situation and the warding off of known danger in order to foster health. This does not imply overprotection of the individual. It is hard for a child to share his parents with brothers and sisters but it is "right" that he should do so, since all children clearly must learn to share. It is "wrong" to frighten a child by asking if his "nose is broken" because there is a new baby in the family; and so also, from the child's point of view, is the often unconscious turning of parental tenderness from the older child to the baby. Such experiences are "wrong" and dangerous for the child in the sense that they breed trouble which could be prevented or lessened, rather than "wrong" because they, and like behavior, reflect our image of "bad" parents.

The individual, whose health we want to nurture, is embedded in and moulded by the group—family, neighborhood, area, national, and international. Nations, or areas within the larger countries, each has its own way of life. Nurses,



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and perhaps public health nurses in particular, have for a long time "taken the community into consideration" and have "seen the family as the unit of work." Many nurses have known their districts or their rural areas with remarkable thoroughness, have been aware of various racial groups within such borders, have known the way the people earned their living and many of the economic and social problems and opportunities that influenced the population. Usually it has been a matter of keen interest to the public health nurse to study these differences and to learn how the facts about health and illness which she knew could best be interwoven with the customs and beliefs of the community. With regard to the individual patient and those immediately surrounding him, the nurse increasingly has tried to see and respect him as an individual and to assess his strengths and weaknesses in a clear, unbiased way.

Granted this is true, beyond the necessary additional knowledge along the same lines and the attendant skills, what is it that we as a professional group are feeling for in order to gain the deeper understanding of ourselves and others that we realize is not yet wholly within our grasp as a professional group and that we need in order to carry out as fully as possible our professional function?

It does not seem that it should be difficult — or contrary to the religious beliefs of any of us — to accept that everyone is quite frequently unaware of the real reasons for his behavior. So many times, after the event, we ourselves have been able to realize that a reaction on our part of anger, of refusal, of blindness to a situation, has taken place because we were afraid or hurt, but that at the time we did not dare, or were unable, to recognize such feelings on our part. It is but a step further to recognize that the conflicts which all of us have, but which would be too painful and disturbing if we were constantly aware of them, lie in a part of the personality called the unconscious. These emotional stirrings plus the outside situation cause us to behave in some way and this behavior takes the form that is most bearable to us. A reaction of denial or hostility may or may not be the best solution in a given instance, but it may seem better than letting ourselves and others know that we are deeply upset or frightened because what we basically and unconsciously

want and what we seem likely to get are not in accord.

A patient with tuberculosis denies he has the disease although it is demonstrable; a patient with organic heart impairment persistently overworks; a doctor rationalizes his reluctance to tell a patient that she has cancer though in this instance perhaps she might well be told; a nation under internal stress becomes aggressive and declares a "defensive" war.

Knowledge of the term "dynamics of human behavior" and the use of this concept as a basis for understanding personality is newer ground to many of us. However, the concept involved here helps to put a more reliable floor under our daily work both with individuals and with groups and, frankly, enables us to work more closely with professions which have had more opportunity to assimilate this concept in their professional training as the material emerged.

This concept of the dynamics of personality is explained clearly and helpfully by Dr. Karen Horney in *New Ways in Psychoanalysis*. She says, "This is the general assumption that the motivations for our attitudes and behavior lie in emotional forces, and the specific assumption that in order to understand any personality structure we must recognize emotional drives of conflicting character."<sup>52</sup>

An acceptance of the dynamics of human behavior provides a basis for understanding people that is becoming a valuable and practical part of our frame of reference and of our relationship to our patients. In the all-important chain of cause and effect, such a concept often explains what "gives rise" and therefore can be a basis for preventive work. An understanding of the dynamics of human behavior is as great a present need of our profession as any that could be stated, and the concept will be welcomed and accepted by us as we learn to apply it practically. Wider and earlier contacts will not necessarily make the epidemiological approach helpful unless a basic understanding of dynamics is brought to these contacts.

The third emerging aspect of mental hygiene which holds special interest for nursing is the fact that we can now see more clearly and specifically not only how a better knowledge of human behavior fortifies the daily work of the nurse, but also how nursing can fit in with the current mental hygiene movement.

There is a current emphasis — almost an insistence — that all those whose professions are primarily concerned with human relationships, whether or not they are specialists in the problems of human behavior, must accept responsibility for that part of the mental hygiene program that falls most naturally within their function. Among such groups are physicians other than psychiatrists; nurses other than psychiatric nurses; social workers other than psychiatric social workers; teachers, religious leaders, industrialists, and, ultimately, administrators in all fields. There is overlapping in function among such groups, and there probably always will be some duplication. However, each has special emphases, special ways of meeting large numbers of people, and special skills.

At this time a good deal of energy is being directed into attempts to reformulate definitions of nursing. For the purposes of this chapter, it seems appropriate to by-pass any attempt to state a general definition of nursing function and instead to remind ourselves of those parts of the health service program which take the largest number of nurses, the most time of nurses, and which bid fair to continue to do so for a long time to come. A description of some of these areas follows.

Considering this country as a whole, most babies are born in hospitals. Therefore, it is the hospital nurse who, except in instances where natural childbirth is used, can give the majority of the babies in this country their first feeling of gentle handling and their introduction to their mothers who then are helped to feed them by breast or bottle. Probably no one would deny that comfortable feeding is an all-important experience to the newborn. Also, nurses are mother substitutes on all pediatric wards, where babies can be harmed by separation from mothers and where older children can learn that a difficult experience can work out well. Nurses are inevitably part of the functioning hospital staff who care for sick and injured patients whose lives and security are threatened. For many of these patients the hospitalization is the first such experience. In such instances as these, nurses reach patients "early" in both senses in which this word was previously used — early in chronological age, early in the experience of a patient of any age.

Hospital nurses and public health nurses are becoming more

closely related professionally. The work of one is often a continuation of the work of the other in a different part of the community health setup. However, special emphases stand out in the work of the public health nurse.

During the second World War when there was a shortage of public health nurses, some parts of the usual public health nursing program had to be given up for the time being or covered less thoroughly. An example of the latter was the wider spacing of contacts with well preschool children. However, there was never any thought of thinning out the work with maternity patients and, in fact, the Emergency Maternity and Infant Care program greatly added to the responsibility of the public health nurse for maternity work during that period. This emphasis continues and means that public health nurses, working in co-operation with physicians, have more contact with parents before children are born than do any other professional workers, and that they could still strengthen this part of the public health nursing program. Similarly, the well baby conference is a known institution the country over. A "natural" opportunity for our front-line participation in the mental hygiene movement is not far to seek.

Another area where the number of nurses and the time they spend mount up significantly is in the staffing of clinics of all kinds, from the well baby conference mentioned above to clinics attended by patients who are very ill. In clinics we have an opportunity for "early" prevention in our work with patients who have this experience for the first time. Given sufficient staff, we can further individualize the patient who comes for a "routine" visit and understand more of the causes of non-attendance — still sometimes called delinquency. This area of our work presents a particular challenge to our skills, for there are "unsuspected depths of bewilderment, conflict, and human need lying just beneath the surface in any group of clinic patients."<sup>87</sup> A quotation from Dr. Lemkau is pertinent here — though all such "quotes" suffer from being lifted out of context:

The people who will have to do the front-line work are the health officers and the public health nurse. I know the nurse is already very heavily loaded and that there are not enough of them for programs already under way. I know how difficult it is to squeeze in 20 or 30 cases in

half a day in a child health station, well-baby clinic or whatever you choose to call the clinics of the Maternal and Child Health Bureau. I know that obstetricians working at top speed in prenatal clinics have a great deal of resistance to talking over with a mother the emotional reactions of herself, her husband, the other children, and a couple of couples of grandparents toward an additional member of the family. Too often the syphilologist can't look forward to attempting to influence his patient any further than getting him or her to take his or her shots or the hated spinal puncture. Still, it is at this level that much of the work must be done, and these are the people who must do it if we are to reach the public with preventive measures. It is at these times, when life experiences can be influenced as they enter the personality structure, that an effort may make the difference between a strong structure and one with a weak spot.<sup>22</sup>

Again, the public health nurse is among those professional workers who continue to see the importance of the home visit. By way of illustration: one agency with about 33 staff nurses now makes an approximate average of 68,270 home visits annually. Because this agency carries a heavy child health conference program and is willing to work quite intensively with a proportion of its case load, the figure is not high, relatively speaking. Yet it is impressive as an index of the contact of 33 public health nurses with families in their own homes whatever the health or sickness problems in those homes may have been, and whatever age groups within the family were involved. When this is expanded to the 25,081 public health nurses (exclusive of industrial nurses) reported in 1950 by the United States Public Health Service as employed in the United States and Territories, it is clear that this professional group is, and should be, very close to the way individuals, families, and large segments of our population think and feel.

In the above discussion, no attempt has been made to cover all areas of public health nursing. One should comment that the public health nurse working in industry is the only one of our professional group who consistently sees the breadwinner—the individual who is still in our culture “the head of the house.” The nurse working in schools is essential. However, by the quantitative method we have been using, the school nurse gives over the front-line position to another kind of professional worker, the teacher of the school-age child, because the teacher sees the child almost daily over a period of years and thus

willy-nilly, in her turn and naturally, becomes a mother substitute, and the person who introduces the child to the more highly controlled group life which he now enters.

This material suggests that public health nurses are not seeking to change their function through a growing interest in mental hygiene but are working toward more accuracy, vitality, and depth of understanding along lines of work already well established in the community. At the same time, it seems clear that some of the nurse's areas of emphasis correlate closely and uniquely with the current preventive program in mental hygiene.

In spite of our individual differences in personality and method, we as nurses have professional purposes in common. Because of these purposes we come in contact with situations in clinic and home and in cooperation with other professions which appear to have basic similarities, although they could not be identical. Also it seems possible to say that the reactions of public health nurses to these situations have certain similarities. In subsequent chapters some of these common reactions and some methods of work are discussed in detail.

## Chapter 2

# TEACHING HEALTH

### »» PART I ««

## *The Relationship between Nurse and Patient*

The teaching of health may seem to be a simpler matter than it was some years ago. At least it is easier to get in touch with large numbers of people. Community organization for health has been growing stronger and there is less duplication of effort between agencies. Our system of communication, including motion pictures, radio, and television, has grown so rapidly that it is possible to bring information about health matters to large and widespread audiences.

Some of this information is essential and well presented. However, some of it, though valid enough in itself, is overemphasized for commercial reasons, and occasionally some information seems downright invalid. Furthermore, broad informative programs, however excellent they may be, often need supplementation or even rectification in order to be appropriate to individuals. Therefore it continues to be necessary that the nurse meet the patient and his family, whether or not health information is available through more impersonal channels.

When a public health nurse meets a patient for the first time, a new situation is created and a new relationship may begin between these two people, one which we hope will result in productive work. However, we realize that the situation is not completely "new." Both nurse and patient have lived a considerable number of years, each in his own way. In addition to this, almost everyone in any community has some preconceived idea of what it is the nurse can do, or wants to do. An increasing number of people realize that she has a useful knowledge of health matters and for this reason will wish to learn all that she can offer, will seek her out, and will use the information well. However, many families still think of the public health nurse primarily as a bedside nurse, to be called in an emergency. Others would like to become dependent upon the nurse in matters of



daily health as well as in emergencies.

Still others will have none of the nurse because they feel uncomfortable with her. Perhaps some difficult experience in the past—which may or may not have anything to do with the nurse—influences them. The nurse, with her knowledge and skill, may seem to the patient to be too “different” to be trusted, bringing with her as she does the discomfort of change. Possibly, too, the nurse’s methods of working with some of these patients may have been unwise.

On the other hand, what does the nurse expect from the patient? She knows that she has something useful to offer him. The obliviousness of many patients to hazards which endanger them and their families, their lack of interest in her work or actual resistance to it, are difficult for her to face since she knows she could contribute to the health of these people. She would like to see them grasp the “facts” quickly and may forget that this information is really useful only as families assimilate it and make it part of their lives. Many individuals and families never will be able to do so as completely as the nurse would wish.

We realize that differences in viewpoint are an ever-present factor in all teaching. To build a relationship between patient and nurse is the means for bridging the gap. Health teaching uses this relationship. The thinking which the nurse does on this subject and the methods of work with individuals and with groups of patients which she develops are applicable to all phases of public health nursing. The nurse needs specific knowledge about the varying health requirements of children and adults, and the best information that medicine can give about illness. But the nonjudgmental, nonauthoritative attitude that leads to a useful relationship with the patient is basic to her work with all age groups and in all situations.

Such a relationship does not usually just happen. It depends on the leadership and understanding of the nurse. It develops through the nurse’s recognition and acceptance of the patient’s problem and the way he feels about it; it depends on the way in which she explains agency function and on her reliable friendliness and help—reliable in the sense that the patient can depend on the nurse to see and sense the situation. She usually sees and senses the situation better than the patient does and therefore

is the leader in building the relationship. She employs her knowledge of him with increasing delicacy and perception rather than using it to impose what seems to her the best solution. Sometimes she realizes that the patient is reacting with inappropriate emotions in one or another situation and knows that a deeper area of feeling has been touched off. The nurse does not "follow him down" in an attempt to find out this material in the patient's unconscious. She glimpses it — perhaps in the way that a mother refuses preparation for breast feeding — and thereby has more knowledge and understanding of the patient. If such buried feelings and experiences come to the surface of the patient's awareness and need to be told to the nurse, the patient eventually will speak of them. The nurse knows that her chief area of work lies among the feelings, experience, and knowledge of which the patient is conscious or almost aware. Her aim is to help the patient to make the most of her conscious feelings and knowledge through mutual trust and interest. Such a relationship can mean a great deal to the patient and is "superficial" only in the sense that it is at or near the surface of what the patient knows and feels. When the nurse is sensed by the patient to be reliable in this way, an identification of interests can begin to take place which will lead toward appropriate health work.

#### THE PATIENT WHO ACCEPTS THE NURSE AND HER SERVICES

It would be oversimplification to say that some patients accept the services of the nurse while others reject what she has to offer. All of us — whether nurse or patient — have mixed feelings about experiences. We are ambivalent in our desires, wanting and yet not wanting. Therefore neither the patient's acceptance of the nurse nor his rejection of her is as complete as it may seem. This means that the nurse cannot relax too completely in a relationship which seems "good" or become entirely discouraged when a patient resists her services. In the following pages, patients in whom acceptance of what the nurse has to offer is uppermost will be discussed first and then patients who appear to reject her work.

Many of the persons who welcome the help of the nurse are

mature and well adjusted. They are glad that a source of information on health matters is available, recognize their own problems, and are even able to see their *own* mistakes. To this group belong the many mothers who return regularly to child health conference and who assume responsibility for carrying out the plans made there. The increasing number of such persons, and in many instances their growing sophistication in health matters delights us even if, once in a while, we must hurry to keep up with them. Many parents in this group know how to observe their children and love to do so, and the nurse in her turn learns from them and has an ever-fresh store of information about the various ways in which families live.

On the other hand, the patient may welcome the help of the nurse because he needs to depend on her. The family of a very sick person "depends" on the nurse to give bedside care or at least to carry out difficult treatments. This is one kind of dependency. The family is temporarily overcome by circumstances and must rely on the special skills of the nurse. However, a person may be so immature emotionally that in times of stress or even all the time he needs someone in the role of parent; or he may be intellectually incapable of meeting his problems. In moments of discouragement one feels that these people form a surprisingly large part of the community. Sometimes the nurse herself temporarily joins the ranks. Emotional maturity appropriate to any given chronological age — infancy or middle age — is hard to acquire and to maintain.

We sometimes think of a relationship in which the patient is dependent on the nurse as inevitably "bad." When the nurse has allowed dependency on her to develop without considering whether it is necessary, the relationship may be bad. Such instances are known to all of us. "Mother wants the nurse to do all the running" is a familiar, graphic statement which tells the story of the mother's use of the nurse as an accustomed convenience, and the nurse's half-irritated realization of the futility of the situation. In such a relationship the mother is not learning to take care of herself and her family. And the nurse herself may be unaware of her own possible over-readiness to mother and to protect patients who welcome such solicitude.

A harmful dependency is an insidious thing, often growing to difficult proportions before the nurse is aware of it, because this kind of relationship may meet her own needs as well as those of the patient and his family. The nurse may welcome the opportunity to bring order out of chaos by arranging clinic appointments for the members of the family when it would be possible for them to make the appointments themselves, and by offering transportation to make doubly sure that the appointments are kept although this help may not really be necessary. She may gain satisfaction from adding to the family's comfort by applying directly to "relief" agencies for material aid instead of helping the family itself to turn to an appropriate agency, and in other ways she may take away from the members of the family many of the responsibilities which they could learn to assume themselves. After a year or so of intensive visiting, the nurse comes to her senses, realizing that although a certain number of examinations have been made and corrections effected, she herself is having to take more, rather than less, initiative in health matters. Most of us can recall at least one experience of this kind.

Nursing records show instances, however, in which dependency appears necessary either temporarily or permanently and in which the nurse recognizes and accepts this need on the part of the patient.

The following situation shows the nurse as a temporary "mother" to a young woman who needed this support and could be helped, by means of it, to mature emotionally. This girl and her husband were very young. Instead of turning to each other for comfort and advice in times of difficulty, they sought the help of their own parents. Both were like children who found themselves away from home on a visit. During her pregnancy the wife spent increasingly long periods at her parents' home. She complained to the nurse, however, about her husband's similar dependency on his parents and relatives. When she returned to her own home after the birth of the baby she felt unequal to caring for him. She remarked with surprise that the baby was "always there." He was not like a doll which, child-like, she could put away when he became tiresome. She began to rely on the nurse for his daily bathing and for repeated advice,

just as she had always relied on her mother to supplement her inadequacies. The nurse felt this to be a crisis in the life of this young woman, a point when she could either become a real mother through the satisfaction of taking good care of her child, or remain a child herself. Clumsy and frightened, the mother moved in an unaccustomed world of sterilized bottles and equipment. However, under careful supervision and encouragement, she became more skillful and able to take increasing responsibility for the baby's care. With this skill came more confidence in her ability in general. She told the nurse that she felt "more of a person." Later this eighteen-year-old girl seemed to be making a home for her baby and her young husband, and even realized that sometimes she had two children on her hands instead of one.

The following instance also illustrates a temporary need for dependence which the nurse could and did fill. The nurse visited a woman who was in the early months of pregnancy — a Catholic woman married to a Jewish man. The man and woman, who were very much in love, had felt that the complications of religious differences and the attitudes of relatives would solve themselves, but they were disappointed to find that this had not happened. The woman, at the beginning of pregnancy, found herself a long distance from her own home, not accepted by her husband's family, and without intimate friends. She did not yet feel able to discuss the problem with her husband. She explained to the nurse that she talked to her about her difficulties not because the nurse could solve them, but because she must talk to someone until she could get things a little straighter in her own mind.

The nurse cannot expect that all patients will arrive at a time when they will have less need of her support. A mother who is not intellectually able to take responsibility herself for homemaking and especially for the care of her child will always need help if and while the home remains together. A woman of this kind married against her family's wishes a man whose habits of drinking were already well established. Although he had lovable qualities which held the affection of his wife and children, his work record was bad. Occasionally the family was in want. Apparently the only important decision the patient had ever made for herself was her marriage, and this, in the eyes of

friends and relatives, had turned out badly. She could not turn to her family in her inadequacy and difficulty because of loyalty to her husband and also because in so doing she would admit that she had been wrong in refusing their advice about him in the first place. She was subject to "slumps" which usually coincided with her husband's periods of heavy drinking. In these understandable periods of depression the mother gave the family an almost unvaried diet of bread, spaghetti, and tea, and forgot matters of hygiene. The youngest of the children, a slight, pale, five-year-old boy, showed listlessness and quick loss of weight when a good regimen was not maintained. This family was known to a family agency as well as to the visiting nurse association and psychiatric consultation was available. The psychiatrist in this instance felt that the mother was reacting favorably to the opportunity to share her responsibilities, that she would always need to do this, and that the nurse and social caseworker might well plan their future relationship with the family on this basis.

Sometimes a question of agency policy is involved in deciding whether a nurse with a heavy case load can visit for an indefinite period in a home where a patient cannot be described as neglected and where no question of the care of children is involved. Such a question came up with regard to continued visits to an elderly diabetic woman living with two grown children whose work kept them away from home during the day and whose refusal to take more responsibility for the patient seemed unchangeable. This woman was not disabled but her foot showed a condition which threatened to become gangrenous and which she neglected unless encouraged by the nurse to take proper care of it. This was a dependency which seemed to justify the continued service of the nurse, whatever one might say about the obligation which rested on her son and daughter to take over the care of the mother themselves.

In the following instance further complications might have resulted if the nurse had followed the mother's desire for dependency. Here the nurse successfully met a trying test by not giving the direct advice which the mother wanted and which she herself would have liked to offer.

In a home visited by the nurse lived an elderly man and wife,

their daughter, the daughter's husband, and two small children, Jane and Rose. The record summary states:

Jane is the mother's illegitimate child by another man previous to marriage. There is a history of apparent early rejection of this child by the mother and of many placements of her which seem to bear this out. Jane calls the grandparents "mama" and "papa" and the mother and stepfather by their first names. The mother now seems friendly to the child, as does the stepfather. The grandmother wishes her daughter would go to housekeeping and take both children with her. The stepfather says he would accept Jane. The mother does not know what she wants to do and asks the advice of the nurse.

The nurse, too, wanted the mother to "go to housekeeping," since the home was crowded and the mother relied too much on the grandmother for decisions on child care. However—with some difficulty—the nurse refrained from suggesting that a separate household would be an improvement. Here was a decision which an immature woman had to make for herself, if the decision were made at all. Otherwise one could expect no permanence from such a step because it involved leaving her own mother's guidance and also accepting a child who evidently represented much that was painful in her life.

The patient who welcomes the nurse may seek to use her in other ways. For example, a mother may accept the nurse's visits or may herself visit the child health conference in order to compensate for her feeling that she is not taking good care of her child, not because she has a mature desire for information and skilled help. Perhaps the child is unwelcome and other interests loom larger. Receiving the nurse or visiting the clinic is enough to relieve her; she carries out none of the plans for child care which result. This may indicate that the nurse should show more interest in the mother instead of focusing her attention only on the child. "The nurse talks to the mother, but she always talks about the baby," is a comment once made in a conference on this point. A number of mothers say that they enjoy interviews with the psychiatrist because they have a chance to talk about themselves. "Mother still rather nervous and inclined to talk about herself more than about the children" is an excerpt from a record illustrating the point that the nurse may see the mother as a mother but not as a person.

While the nurse may have considerable difficulty in understanding and accepting the problems of the psychoneurotic patient, such a patient often accepts the work of the nurse readily.

The following illustration has, in spite of its pathos, elements of humor for those many nurses who have had experience of such a household, but the recognizable personality difficulty it describes might have become more exaggerated had the nurse unthinkingly allowed the patients to make use of her. An elderly husband and wife, pathetic in that their lives had been lived too barrenly to provide interests in their old age, looked forward to the nurse's visit. They seated her between them and vied with each other in relating their physical symptoms, interrupting one another in rivalry for her sympathy and ending in a quarrel. All attempts to divert them failed. With the consent of the medical clinic, the nurse closed the record, feeling that she was doing more harm than good by listening to the patients' symptoms. A psychiatrist suggested, when consulted about another puzzling situation of this nature, that the nurse in the role of listener is helpful to the patient only when he continues to bring out new material and when he seems quieter and more comfortable after talking to the nurse about his difficulties. The repeated expression of the same problem with undiminished emotional intensity may enhance rather than relieve it.

A method of using the nurse that may well give health workers pause was described by a social worker in a family agency which maintains a summer camp for children. Children from underprivileged homes longed to go to this camp but facilities were limited and many had to be excluded. The children had learned that as a rule undernourished children were given priority. A number therefore reported for examination after having omitted one or more meals in order to weigh less and to look pale and tired. The social worker in describing this situation commented that sometimes we seem to offer rewards for ill health. She went on to suggest that many special diets issued only on physician's order to families on an extremely limited budget have the same effect. Given sufficient strain, it might be only a short step from such conscious use of symptoms of poor health to actual neuroticism.



In most communities the nurse has little part in giving financial aid. Patients, therefore, may accept her as a generous person in contrast with the social worker, who sometimes provides such aid but sometimes must withhold it. It is difficult for the public health nurse not to gain some satisfaction from her reputation for generosity. However, the family may be voicing bitter complaint over the social worker to the nurse to avoid more realistic thinking about their difficulties. A case in point was described by a nurse who reported the distress of a family over the small amount of relief given them. The social agency found that an allowance somewhat larger than the minimum was being supplied. Budgeting by a nutritionist was accepted by the family with revealing reluctance. Presently the family shifted to equally bitter complaints against the school which the children attended.

These are illustrations of the ways in which patients who accept the nurse seek to make use of her. They range from constructive use of her superior knowledge of health by people in need of advice in such matters, through an emotional dependency which may help or hinder according to the individual situation, to an attempt, often unconscious on the part of patients with marked personality problems, to fit her into the defenses they have worked out for making life more endurable.

#### THE PATIENT WHO IS RESISTANT TO THE NURSE AND HER SERVICES

As stated earlier, individuals are ambivalent about accepting what the nurse has to offer. They want her help and at the same time they are loath to get involved in ideas and plans that mean change. Change is a threat to established daily living which in itself may not be very comfortable, but which is more comfortable than change. Change brings the necessity for thought and for decision, with subsequent feelings of discomfort about the decision unless happy results are quickly obvious. "Mother says what she thinks the nurse wants her to say," may be an appropriate illustration.

Some of the psychological factors underlying resistance to progress have been stated in terms that seem to apply almost directly to the work of the public health nurse in an article by

Bernhard J. Stern entitled *Resistances to the Adoption of Technological Innovations*:

The adjustment of a person to his environment demands that he channelize his behavior to some extent in the interests of personal integration. He cannot be continuously expending his energies and undergoing crises in making decisions. Judgments once made must serve as guiding precedents. A large part of his behavior of necessity becomes quasi-automatic involving little deliberation or judgment. This behavior, oft-repeated, becomes suffused with emotional tones of pleasure, particularly when it involves skillful movement. One's personality becomes relatively at ease when it has attained an element of equilibration with the objects and persons with whom he comes in contact. Personality becomes bound up with environment by sentiments of intimacy. The strength of these attachments varies depending upon the degree of the stability of the culture in which one lives. . . . An innovation . . . rudely shatters whatever equilibrium a person has attained. It demands not only motor reconditioning but reorganization of personality to meet the needs of the new situation.<sup>66</sup>

The nurse realizes that this is true of foreign-born families who seek living quarters where they will be near people of their own nationality and who cling to familiar customs in the insecurity of a new land. What we sometimes recognize less clearly is that everyone, nurse and patient, entrenches himself in habitual ways of doing things. Even if we believe that we are reconciled to new ways of thinking or to new methods, we may find that these innovations tire us and are hard to maintain. It is especially upsetting to all of us if too much that is new is presented to us at one time, or if we are expected to change our *attitudes and methods quickly*. In fact, a certain amount of fear and resistance is recognized as being part of all new learning situations. Slow acceptance of what is a departure from habit is both more universal and more natural than we sometimes realize. The way in which new styles, new forms of recreation, new devices can sweep our country, seems to refute this. However, perhaps such innovations fit so well into our way of life that they require no basic change on our part.

Social scientists now recognize that individuals, and groups and peoples as well, are capable of change, but that it is a slow and difficult process. The Preparatory Commission of the 1948 International Congress on Mental Health suggests that "many social patterns seem to those who use them to be as changeless

as if they reflected some property of Nature, quite beyond any possibility of being altered." <sup>54</sup> Yet history shows they have altered. The Commission points out two important reasons for resistance to change: ". . . the failure on the part of persons using these patterns to understand fully the nature of the patterns, and second, the fact that people using them are not necessarily aware of the purposes the patterns are serving."

The childhood experience of learning also influences attitudes toward change. Learning, at home or at school, may or may not have been made pleasant and interesting to a child. If it has been a bad or too difficult experience, he rebels against any apparent repetition of it. Many individuals have never worked through the usual stage of adolescent rebellion against authority and so turn against any relationship that seems to them to have a tinge of parental guidance. They have not learned to steer their own ships safely, yet they feel they must refuse a pilot.

Individual experiences may strike so deep and involve so much of the patient's life that his rejection of his situation, and of anyone like the nurse who becomes involved with it, is very definite and real. To such a patient, the nurse is identified with the trouble which he cannot yet face or incorporate into his plan for living. A young man, formerly a brilliant college student, was a post-sanatorium patient who needed careful follow-up. He told the nurse not to visit him, saying bitterly that he knew all she knew about tuberculosis and did not want to be reminded of his illness by her presence.

The nurse had been visiting in another family where the father had tuberculosis. For unexplained reasons, this family considered tuberculosis a shameful disease. They did not inform friends or even relatives that the man had entered a sanatorium. The illness was a financial hardship since the man's business suffered when he was not there to direct it. The mother shrank from the nurse although she allowed her to come into the home. She evidently felt toward the nurse some of the dread she felt for the disease which had brought the nurse into the family. On the father's return from the sanatorium the mother became pregnant, a pregnancy she did not welcome. When the nurse turned to the subject of the pregnancy the mother said, "I don't know why it is, but even when you talk about the pregnancy you

remind me that we've got tuberculosis." Here was a serious obstacle to the work of the nurse, but here also was proof of a promising relationship, since the mother felt enough at ease to voice her feelings.

Other experiences that may form a barrier between patient and nurse and are familiar to us include clinic visits that have been unpleasant for the patient or unhappy relationships with previous nurses or with other agencies or institutions. The patient may identify the nurse with these experiences. His reaction may be reinforced by guilt or fear over his own share in the past unpleasant episode. For example, a man who had a jail record and who came of a family well known to the police, refused to allow his wife to answer the nurse's knock because, as he expressed it, the nurse was "just looking for more trouble." A nurse's record says, "Mother is afraid of the nurse because she identified us with the agency which found out that she and the father are not married." In fact, many refusals to return to a doctor or clinic for further examination or care, attributed by the patient to unsatisfactory treatment, are more truly a picture of the patient's unhappiness and embarrassment due to personal problems.

The nurse meets adult patients with whom it is exceptionally difficult to work because of their ingrained sense of insecurity, aggravated often by the sense of difference which the nurse's superior health knowledge may create. Unhealthy ways of meeting problems have become habitual and now constitute an actual personality defect.

On the other hand, resistance is not always just obstructive. Some resistance can be expected in any contact between nurse and patient, for such a contact is a "dynamic, moving, organizing and reorganizing relation."<sup>7</sup>

The nurse herself can contribute to resistance on the part of the patient. She has certain professional standards of living which it is hard for her to see disregarded. These professional standards may be influenced by personal standards to an extent which she may not realize. The nurse has also an inevitable emotional reaction to what occurs during a visit. Ultimately she may be objective about these feelings and learn to be less disturbed by them, even to make use of them. A negative re-

painstaking efforts seem to have been ineffectual — is often quite understandable. The nurse herself may deplore it and banish it from her consciousness as "unprofessional," but it is still a part of her. The nurse's ideals for her own conduct influence her methods of work with the patient.

At one time it seemed that a hunt was abroad in the land for what sometimes was termed the "ideal public health nurse." Some people felt that "mental hygiene" might define what such a person should be like. Certain personality standards were listed to which it was felt "good" nurses should conform. It is easy to see why the need for the perfect nurse should be felt when professional demands on her are so great. However, we were at that time occupied with the more superficial characteristics, which we have since learned, partly through the reactions of the families the nurses visit, are relatively unimportant. Sometimes the very quiet nurse who was thought to have too little "initiative" is successful in working in a home where a nurse with more poise and drive has not succeeded. One family telephoned to a nursing organization to say that they would like a change of nurses. They explained that the nurse who was giving bedside care in that home to an elderly woman was "so healthy that she depressed the patient." If we attempt to set up a model personality as one of the accepted public health nursing requirements and to mold ourselves dutifully after this, we may well achieve an effect opposite to the one we hope for. We may be caught in the superficialities of "popular psychology," in this way creating discouragement, fear, and rebellion in those whose interest in nursing is so deep that they would try to achieve an impossible "ideal personality."

Instead of thinking about our characteristics and behavior in the abstract or endeavoring to set up and conform to specific personality standards, it has been found more valuable to study our behavior in relation to given professional situations with the idea of growing in awareness and understanding of our own reactions. This is more productive than acceptance of certain personality patterns as appropriate to all nurses under all circumstances, and the exercise of self-control to meet these standards. In the realm of the emotions, self-control should be an emergency measure.

Many of us have difficulty in recognizing our own emotional

reactions, or in trusting them when we do become aware of them. Perhaps those of us who are products of New England have a traditional conception that all emotions should be put down. We may mistakenly interpret emotional flatness and lack of response as "objectivity" and may be unwilling to call emotions by name — to admit that what we feel for a certain patient is anger or dislike, and for another, an unusual degree of friendship. Suppressed emotional reactions on the part of the nurse may be a source of danger to the patient. If her own anger, for instance, is not recognized as such by the nurse, she may interpret some of the patient's behavior adversely without knowing she is doing so, or may quite unconsciously punish him for what he has done. For example, she might decide that a patient did not need a visit on the following day when unclouded judgment would indicate that the visit should be made.

We can do more than recognize our emotional reactions: we can make use of them. We can trust some of them as guideposts. For example, how shall the nurse meet her dread of returning to certain homes or communities where she found considerable resistance to her services? Disregarded, this feeling may find an unrealized outlet in postponing these visits, in moving them back further and further in the date file. We may rationalize such a process, giving ourselves apparently excellent reasons why the visit cannot be made today or tomorrow. However, if the nurse recognizes her feeling of frustration and resulting anger, she may also understand the wisdom of *thinking through the situation again*. Through this rethinking she may gain awareness of factors which underlie the family's rejection of her, find new ways of working with this particular situation, accept the possible limitation on her work which the habitual reactions of the family may continue to impose, or perhaps come to realize the advisability of closing the record because the limit of improvement possible at this time has been reached.

When the nurse is unaware that her judgment is governed by her own standards, her blind spot may cause her to stumble in developing a working relationship with the patient and family. The first illustration that comes to mind is one familiar to all of us. We, as nurses, like cleanliness and order. Perhaps the very need for them sent some of us into "training" in the

first place. Hospital cleanliness, especially aseptic techniques, strengthens such a tendency. As a result, we sometimes put aesthetic values ahead of more fundamental ones. We may sacrifice a relationship which could lead, for instance, to the immunization of a child because we are impelled to suggest to a mother that she clean up her home.

A Scandinavian nurse and a Chinese nurse, students in public health nursing at one of the universities, were doing field work. The Scandinavian nurse had lived until recently in a small, immaculate country. The Chinese nurse came from a large, very crowded land where many people lack modern sanitation and health measures. The Scandinavian nurse was shocked by the dirt she found in the homes she visited and at first could not "see beyond it"; the Chinese nurse, on the other hand, while she was aware of the poor living conditions, could see the other problems the families presented.

The following example from a nursing record illustrates what a formidable barrier to relationships a nurse's standards may be and also how the nurse's attitude may bring about a change for which she does not work directly. The family consisted of a young man and his wife, two preschool children, and an infant. The record written by the previous nurse states, "Woman is very slovenly about her housekeeping and untruthful. Yells at children. Has done few of the things the nurse suggested regarding preparation for delivery and the new baby." Coming fresh to the situation, and with less need to stress the poor homemaking, the new nurse eyed with hope the few accomplishments of the mother and resolved to keep away from the subject of housekeeping. The mother continued to "yell" at the children and was not interested in better ways of getting along with them. Therefore the nurse avoided this subject as well. She found that the mother wanted help on certain very concrete matters of feeding and immunization and for the time being limited herself to these. Mother and nurse began to feel at ease with each other. The mother secured beds for the two oldest children on her own initiative. One day the nurse found the mother hemming curtains for the kitchen. On her face the nurse noticed what seemed to be an expression of surprise and reluctant pleasure as she sewed.

Sometimes the nurse's standards of cleanliness and home-making bide the picture of the real progress she is making in a home. A nurse was very much discouraged about her work in a certain family and wondered whether she was justified in continuing. The parents were foreign born; there had been eight pregnancies, with six living children. The family was known to a number of family and protective agencies. The home was always dirty and cluttered and showed the familiar collection of unwashed dishes and poorly washed clothes. Over a period of months the homemaking had not improved. But in the record one found such unmistakable signs of progress as these: the diet for the younger children had improved and the mother was giving the baby cod-liver oil; all the children had been immunized against diphtheria. In other words, much actually had been accomplished, as would have been recognized by the nurse had she not been blinded by her own homemaking standards, which were too high for this family to meet.

We have ideals of family relationships and of individual behavior and, as with our standards of cleanliness and home-making, it is difficult for us to have them violated. Sometimes the nurse's standards of family life are not appropriate to a particular situation. Time may be saved and relationships eased when the nurse is aware that she cannot expect everyone to have the same standards for behavior that she has. For example, the nurse first entered a certain comfortable home when the mother was five months pregnant. She made the visit at the request of one of the mother's friends. At first the mother turned the conversation away from the pregnancy. Later she said she did not want the pregnancy. Subsequently she told the nurse she did not like to cook or to keep house. The nurse, able to accept the mother's point of view on homemaking although it did not agree with her own, did not urge her to greater effort or suggest "comfortingly" that her feelings would change. Perhaps partially as a result of this, the nurse's visits became increasingly welcome to the mother and were directed more and more toward antepartum care and toward preparation for the coming baby.

In contrast to this, it sometimes happens that a possible working relationship may be sacrificed to the nurse's personal standards of behavior. A nurse was visiting "an apparently unstable



young couple" who lived in a rooming-house district. The man was in frequent difficulty with the police. The woman loved to dance and spent "too much" time in this way away from home. The baby was neglected. The mother did not prepare his food properly. Here the nurse, both in the record and in conference, was frankly intolerant of the mother's standards and expected the mother to accept readily her rather rigid standards, although mother and nurse were as different as two persons could well be. Each had the standards resulting from her experience and training.

Another mother apparently knew quite well how to carry out the nurse's suggestions but just took what was to her the easiest way, and lived from day to day without a plan—a method of living at variance with the ordered habits of the nurse. This mother, who was pregnant, had "poor standards of care for herself, for her baby, and for her house." In these respects her standards were so different from the nurse's own that the nurse felt impelled at last to tell the mother what she thought of her poor homemaking and child care. The crisis was precipitated when the nurse entered the open kitchen door to find the year-old baby half out of the crib while the mother gossiped with neighbors elsewhere. The nurse was frightened for the baby, with reason, and because her sense of values was shaken by the fright felt she was voicing "righteous indignation" by her protest. In response, the mother, unable to face the fact that she was giving her child inadequate care, flared back at the nurse, and then subsided into pacifying promises. The nurse realized she had allowed her own standards of homemaking and child care to lead her down a blind alley.

Understandably, a nurse may feel that she is accepting the *patient's standards* for her own, or at least lowering her own standards, when she condones behavior such as we have been describing. However, we are learning that we make better progress when we can accept the patient as different from ourselves, and recognize that each is the product of a particular environment and is equipped with a particular degree of capability. Somerset Maugham speaks of a sympathy which should be as wide as knowledge is universal, and based "not on a general difference, such as makes men tolerant of things they

care nothing about, but on active delight in diversity." Dr. George K. Pratt said to a nursing group, "Take the situation as it exists and rub out of your vocabulary the word 'ought.'" This is sound thinking, but one realizes also that it is easier said than done. A clean house is on the whole more to be desired than a dirty one. A mother who takes care of her child is more of an asset to society than a mother who neglects her child. Immunization does save children from illness and possible death. These are axiomatic truths closely tied in with the professional purposes and philosophy of the nurse. The material we have been discussing shows the danger of inappropriate response when our professional purposes are seeded with unrecognized emotional needs and reactions.

As the nurse becomes really interested in the meaning of her behavior in relation to the job, she often "catches herself out" by rereading a record and studying the terms she uses most frequently and the methods she records. She will see for herself that sometimes she trips over her own standards, though quite as often she will be encouraged by evidence of thoughtful work. When, for example, we find something like the following on a record we have written, shall we say this is just a manner of speaking, or may it mean that we actually were in this instance an "authoritative" person?

Child asleep in mother's bed. *Told* her not to get him used to this. *Told* her to put him back in his own crib. *Gave* medical appointment for June 7, for formula adjustment—not getting CLO for rest of summer. OJ occasionally. *Told* mother she should try to give it every day.

Again, when we describe a patient as "just plain lazy," and leave the description there, we are saying that we do not like lazy people—we who must hurry—and may be forgetting that laziness is a symptom, not an entity in itself.

Of the various forms of behavior seen in the patient, behavior called "neurotic" has been one of the most difficult for nurses to accept as symptomatic. The reluctance to accept neurotic symptoms as valid goes back to the days when few people recognized the emotional element implicit in all illnesses. Perhaps it was an indication that we wished our busy days occasionally granted us an opportunity to be a little "neurotic." At any rate, the so-called neurotic patient appeared to violate the stand-

ards of desirable behavior. Even when we have learned that the patient of definite neurotic tendencies is showing symptoms of deep trouble, so painful that he cannot meet it directly but unconsciously converts it, for example, into the more socially acceptable symptom of physical illness, we may still fail to understand his need. We sometimes accuse or perhaps defend him. The familiar phrase, "He's just a neurotic," may still come to the tongue of doctor or nurse. The patient may well be neurotic but as we now know, that is the beginning of our understanding of his difficulty, not the end.

Some nurses have difficulty in discussing family finances with patients when a decision regarding fees or free bedside care makes this necessary, or when the patient might be benefited by working out a budget. One nurse said repeatedly of a patient that he could not endure a discussion of money matters. During this nurse's vacation a substitute nurse cared for the patient, returning to say with surprise that the patient did not seem to object in the least to discussing family income in order to adjust the fee. In this instance the first nurse realized she had been projecting onto the patient her own discomfort in such a discussion. Sometimes a nurse who has a great need to give shrinks from accepting a fee for the organization because she then feels she has not really given herself and her services. This is another instance of a personal need confusing a professional issue.

When we recognize the individual differences and needs in patients and can accept the fact that what we offer must be modified to suit such differences, our methods will be less likely to create resistance in the patient. We are then ready to teach the patient, rather than the subject matter. A record reads: "Discussed this (the fact that no 'discipline is evidenced in this home') at length with the mother who apparently has no patience or interest." The somewhat humorous picture which *this excerpt calls to mind* cannot hide the unfruitful teaching and the nurse's discomfort in it.

The same point is illustrated by the woman who telephoned a nursing organization to say that she did not wish the nurse to call again. She said that the nurse had come to her home and "said a piece." As a matter of fact, this nurse was a student affiliating with the public health nursing organization. One

sympathizes with the insecurity which made her plan her visit to the last detail before she entered the home. When she found that her plan was inappropriate, she had not yet gained sufficient flexibility and grasp of content to adjust the material to the situation as it actually was. A more experienced nurse or student would have made herself as familiar as possible with the family before entering the home and would then have followed where circumstances led. However, it is interesting that even the "older" nurse may fall back on the use of a dogmatic method when a patient asks a question which she feels unable to answer adequately or when she is on comparatively unfamiliar ground. Just as it is the mature patient who can accept the fact that he knows less about health matters than the nurse, so it is the mature nurse who is able to respond to a question she cannot answer with the words, "I don't know enough about that to answer you fully, but I'll be glad to look it up."

A mother who is obviously lying to the nurse presents a most interesting problem not only because of the resistance this shows, but because of the nurse's part in creating the need to lie. Often it can be observed that the nurse reacts to the mother's untruth by a sense of injury. She has been taught that it is wrong to lie, and she also feels that the lie is unfriendly behavior on the part of the mother, shutting her out. Again, the more authoritative the nurse, the more she feels in such circumstances that the mother is attempting to mislead her. She resents this personally and also as an agency representative, and may feel impelled to show the mother that her lie is unsuccessful. She may first attempt to conceal her feelings from the mother, and even from herself, because she "considers the source," and then later she may see that she was patronizing the mother by thinking in this way.

If we consider where the real source may be, we find it in a relationship which has not been thought through, a relationship of which this behavior on the part of the mother is a symptom. To the mother, whose uneasiness perhaps is fed by awareness of her own shortcomings, the nurse may mean authority whether or not her methods justify the mother's attitude. The mother may then lie through fear. Or the nurse may represent standards which to the mother seem unattainable. Or the mother may be

reacting to the inappropriateness of the information which the nurse is presenting with considerable insistence.

For example, a mother tells the nurse she has attended the antepartum clinic. When no report is received from the clinic, the nurse discovers that the mother has not told the truth. It is futile, of course, to tell this kind of lie since the facts must inevitably be found out. The crux of the matter may be, however, not the mother's behavior but the pressure the nurse has brought to bear on her which drove her to such lengths.

"Mother *denied* neglecting the baby" is a revealing quotation from a record which in spite of its brevity reveals fear, on the one hand, and authority, on the other.

"Mother not telling the truth half the time" suggests that this behavior on the part of the patient is to the nurse a baffling characteristic rather than a symptom of a relationship between patient and nurse which needs rethinking. "Neighbors complaining about the mother's care of the children; mother lies to the nurse about this" suggests the factors found in both the previous quotations. The following is an amusing instance of a mild lie which, however, shows resistance. "Mother says Robert breathes through his mouth only when the nurse is there." Still another record suggests in only too familiar terms that the nurse represents standards of hygiene and child care which the mother is not accepting: "Mother seems very slack. But she glibly recites all the routine she has for the children."

The mother's defensive behavior may be a reaction to special aspects of the nurse's teaching which it is particularly hard for her to accept. The following notes from two records appear to indicate this: "Mother still giving bottle though she says not. Has no difficulty in training this child otherwise." "Mother still nursing baby. Says she does not, but Mary, five years old, says the mother does and realizes her mother is lying. Mother is a 'good promiser.'" Awareness that weaning holds emotional or other difficulties for these mothers might have helped the nurse to a less insistent and more appropriate approach. It is even possible that breast or bottle feeding should have been continued for this baby, and that the mother was right in her insistence on it.

The following situation is in contrast to these and is typical

of the way in which many of us are now working. It shows the attempt of a nurse to see the significance of the mother's behavior and to adjust her teaching to it. The nurse's record states that while the mother says her two small children are toilet trained, it is quite obvious that they are not, although they are old enough for training to be appropriate. The nurse wonders why the mother must attempt to misrepresent conditions in this way. She concludes that the mother does not reject her services since she brings the children regularly to child health conference at considerable inconvenience to herself and carries out some of the simpler plans made there. She notices that the children, and their mother also, are pale and have circled eyes. Physical examination showed the mother to be anemic. Perhaps the added work of toilet training two small children is more than the mother can face at the present time, but she does not wish to appear inadequate as a mother. With this in mind the nurse is thinking now in terms of the more basic and general problems of the family, with the toilet training of the children as a future by-product of the mother's improved health.

Unhappy results such as some of those described make us realize how futile it would be to continue to put the emphasis in teaching entirely on the content rather than on the individual with whom we are working. This would be teaching on the intellectual level only and might well be inappropriate to the needs of the patient as a person. We shall go astray and defeat our own purposes if we attempt to meet resistance on the part of the patient with arguments and statistics instead of trying to understand what lies behind his behavior and to adapt our teaching material accordingly. Study of the actual need of the patient will help to make the material appropriate not only in general, but also in specific situations. We shall resort less often to "general advice on diet," for example, or to the statement, "I cannot reason with this mother."

Another record is especially interesting because it shows how barren so-called mental hygiene material may be when presented on a purely intellectual level. The record says, "Mother cannot seem to accept nurse's explanation of food fads as attention-getting."

"Mother has no use for *scientific* diets," has been a familiar

quotation from nursing records. It indicated how far apart the nurse and another woman may be on the subject of food—a topic which is of common interest the world over.

The suggestion that the information which the nurse gives to the patient shall be “specific” needs simplification and modification. It is true that information or procedure prepared by the nurse down to the last detail in advance of a visit may fail to fit the real need and so may weaken the relationship between patient and nurse. But the nurse who has prepared *herself* in advance is always at an advantage. If we need a sphere of activity in which to give full play to our appreciation of order and exactness, the giving of specific information would seem to be the sphere. When the patient inquires of us what action to take in a difficult life situation, often in wisdom we cannot tell him. On the other hand, when he asks us for information on such matters of health and sickness as are within the province of the nurse, we are only fulfilling our function when we give an entirely accurate, point-blank answer, within the limitations of present knowledge, immediately or as soon as we can procure the desired information.

It has already been pointed out that a successful visit cannot be carried through on an intellectual level only. This, however, does not mean that the giving of accurate information on the subject under discussion is anything but essential. A difference exists between giving desired information and offering advice that is not asked for. We ourselves know how helped and stimulated we are by a conference, book, or lecture out of which we “get something.” On the other hand, we are exceptionally exasperated—experience a sort of intellectual insult—when the information has been vague or beside the point. In this connection it can be noted that occasions still present themselves when apparently conflicting information is offered by two nurses with whom the family has contact or by two community agencies that are not working in close cooperation. Such a situation plays its part in creating resistance in patients.

But information which really helps must be appropriate as well as specific. Understanding the emotional aspects of the situation will keep us from giving information at inappropriate moments. For example, it was said of one nurse during her early

days in public health nursing that she could not seem to refrain from telling the truth, the whole truth — and at the wrong time.

Many inadequate patients and families have to be given the same information repeatedly, even when the facts are specific and are offered at the right time. The days have passed, however, when, faced with apparent failure to interest a patient, we resorted to wartime tactics and felt that we must "fight it out along this line if it takes all summer." Instead, we accept such failure as a signal that we must again stop and consider why patient and nurse are unable to meet on common ground.

The following more detailed illustration is taken from the report of a very good nurse who had learned that her own reactions were important in the situation but who still did not understand the need to reconsider her approach in relation to the specific situation:

During the past winter I made three calls to a family for the primary purpose of having an infant immunized against diphtheria. Traveling to the house entailed physical hardship for me (weather inclement; snow not removed from the streets so that I had to wade through several long blocks of it). When I arrived at the house it was in a state of chaos — dirty, untidy, and looking for all the world as if it needed a good cleaning and straightening out. (Three adult women at home.) I saw the mother and tried to impress her with the need for diphtheria protection and medical supervision. The next two visits were almost the same with no return of the mother to Child Health Station. My next encounter with the mother was in school where she was registering her daughter. She promised to keep the appointment for immunization if I sent it to her. No results. The baby still is not immunized.

I did not realize how this woman had provoked me until a teacher referred the school child to me because she seemed to be hard of hearing. I found myself almost unwilling to offer any assistance to this teacher and child (who obviously need and are entitled to the best I have to offer). I suddenly got hold of myself and realized I was "taking out on the child" the frustration I had because of her mother. I was ashamed of myself. If it was difficult for me to travel to her house, it was twice as difficult for her to travel with a baby carriage to the Child Health Station.

The interview with the teacher took place yesterday morning. I sent home a notice for parent conference and expect the parent to respond. If she has not responded in a week, I plan to make another visit. On this visit I'll do a good job of public health teaching or bust. I'll disregard, as much as possible, all the disagreeable physical factors and try to start anew. I might even be able to get her to the point where she will have a desire for a clean house and will have her infant immunized and her schoolgirl's



hearing defect treated. I know that I have been influenced by my attitude and feel that it is responsible in a large degree for the mother's lack of response. I feel that my own recognition of this, without having it pointed out to me by someone, is a step in the right direction and ultimate success. I might add that the weather man will be with me now, too!

No one could fail to like the nurse who is telling this story about her better understanding of herself, or to admire her spirit. But will her new strength and determination lead to success unless she thinks the situation through and centers her work on finding out what the mother thinks and feels, what her interests and problems are, and fits her teaching appropriately into these?

Such situations need to be thought through further because the nurse's concept of her purpose may be limiting the relationship between patient and nurse and the progress which might be made — perhaps along important lines which the nurse does not yet know the family well enough to glimpse. The fact that sometimes the nurse is pursuing her own objective rather than the objective of both nurse and family helps to explain the difficulty of a nurse who, discouraged by failure to interest a family, asked her supervisor for "more talking points" to bring to bear on the mother. It seemed, in considering the difficulty, that the nurse's better understanding of the mother as a person — her needs, strengths, and interests — would bring reality to the situation, while giving more and stronger reasons in favor of what the nurse felt needed to be done would only make the predicament worse.

A similar need to reconsider, together with a half-recognition of this necessity, lies in the words of the nurse who said of her work with a family that she had "run out of suggestions." She had reached a dead end and was dimly aware that the road she had taken led nowhere. Possibly further study of the problem would have enabled her to see a way out, using the patient's needs and circumstances as a guide rather than an obstacle to progress. It is interesting and significant in this connection that our records, while they faithfully set down the nurse's "repeated advice," still do not always record the patient's response to the advice. We certainly have very little time to write our records. But even so, we find time to record what we or our agency thinks

is essential and it may be that we sometimes see our own activity as more important than the patient's reaction. How does one know how to follow suit if one does not pay attention to what has been led?

When we meet problems of resistance in the patient, success may seem improbable if by success we mean helping the patient to the full enjoyment of good health for himself and his family. However, professional success in such difficult situations may consist in getting as accurate an understanding as possible of the limitations to progress. Extreme poverty, intellectual inadequacy, outstanding personality problems—these constitute such limitations at the present time. We shall work more economically and have a sounder basis for the allocation of our time and endeavor in the light of our growing understanding of our preventive function if we accept the limitations imposed by circumstances. To some nurses this philosophy lacks force and courage. They would rather hatter away at the obstacles. To some extent such determination may be a wolf in sheep's clothing—perhaps an unrecognized desire to put oneself over in a given situation. It is true, however, that one cannot always be sure one has been accurate in estimating how far certain family or individual circumstances are "limiting." Also, a saving point for those who find it hard to give up trying is the fact that much work may still remain to be done before we reach the limit. Sometimes a willingness to define in this way results in a discovery of possibilities instead of a decision to close the record. We ask ourselves once again, "What about that 'hopeless' family? Within the limits imposed by their individual and family circumstances, can any plan still be worked out?"

We have come a long road toward a real acceptance of the patient and his mode of life. Many of us can remember when records frequently bore the closing statement, "Case closed; patient uncooperative,"—in other words, the patient refused to be interested in our teaching or in doing what we wanted him to do. The burden of the failure was placed on the patient. The fallacy of this began to be recognized and, as a next step, we wrote in our records under similar circumstances, "Unable to gain the cooperation of the patient." Many of us were conscious of some artificiality in such a notation, but it was a step forward

to include ourselves in the situation. Perhaps we felt dissatisfied with the phrase because it only pretended to be objective, while in reality it retained much of the authoritativeness of the original statement and lacked its honesty. In writing it, we were saying that it had been impossible to bring the patient to an acceptance of health measures that we believed would be good for him and his family, but that we ourselves were somewhat at fault in not achieving this. It was still our own professional point of view and analysis of conditions that we wished the family to accept. "How can I get a better relationship with Mrs. X so that I can induce her to take better care of her baby?" is a familiar example of the way the nurse thought of the relationship to the patient, primarily as a tool to be used in building according to her own blueprint. But today we seem to have reached a third phase in our relationship with patient and family. We are attempting to find out what it is that the patient wants from the nurse and what, because of his individual capabilities and situation, he will be able to use. It is *his* situation — *his* life — and the nurse is beginning to accept this and to feel more secure in letting the patient take what he can of her information and skill. Often his ability to take will increase as the relationship continues.

Perhaps this is as far as one can go in "motivating" the patient. New knowledge in itself may be exciting and stimulating to the patient and may give him an incentive to further effort. Although it really comes slowly, as the person becomes ready for it, new knowledge can seem like sudden new light by means of which the person sees previously unrelated things more clearly and then, with more confidence, can move forward. This only happens when information and facts are warmed to life by coming close to a need or feeling of the individual which means a great deal to him, even though this feeling may not seem important to someone else. Actual interest in the patient's point of view and respect for it — not assumed respect as a device for sugar-coating her "message" — plus sound, appropriate health information based on available research, plus skill in bedside nursing, plus belief on the part of the nurse that her professional purposes are of value gives us a working formula which includes the emotional aspects we have been considering and

makes the patient feel that identification with the nurse is worth while.

This is one of the most difficult and thought-provoking points in the application of mental health concepts to public health nursing, and raises in some people's minds an apparent conflict between the two. On the one hand, the community holds the nurse, among others, responsible for teaching health to people. Teaching health frequently must include, for example, the attempt to convince a patient that it is advisable for him to go to a sanatorium or in other ways radically to change the course of his life. Not only is the nurse held responsible for "progress" in many such instances, but pressure, sometimes political pressure, may be brought to bear on the organization of which she is a member to "show results." On the other hand, the nurse is dealing with the complex lives of people. It is a question how far we may intrude on them. Perhaps it is possible to reconcile the two points of view when we realize that our recognition of people's complexity and the ways in which the nurse may relate to her patients and their health problems is just as literally public health nursing as the application of medical facts.

The ways we have discussed of bridging the gap in the relationship between patient and nurse are appropriate to the nurse who covers large areas and who sees her patients seldom, or for the most part in groups, as well as to the nurse who carries an urban case load. At some time in the future, rural areas will have a more adequate ratio of nurses to population so that the nurse will have more opportunity for individual work. However, all nurses, under whatever conditions they work, can ask themselves, "What do I represent to the patient?" "What does this patient or group want?" and act on the answers they find to these questions.

The development of a working relationship between nurse and patient may be a slow process, and for this reason rural nurses may have the advantage. Nothing hurries the turn of the seasons or the succession of the crops. Those who live or work in the country come to a useful realization that growth takes time. A mother seen by the nurse briefly and only once may come back to the nurse a year later. The relationship may not have stood still meanwhile. The interest which finally brought the

mother back to the nurse has been at work and may be strong enough now to result in action. What might have been only superimposed upon her before is now a part of her.

It is not easy to go slowly, to stop for thought, to be aware of our own reactions, to be willing to relate ourselves to the lives of others rather than to direct them. But increasingly we realize that this is the straight road to a working relationship with the patient.

## »» PART II ««

### *Working with the Individual Patient*

"If I have helped them and haven't understood how I have done it, I haven't helped them very much," said a psychiatrist in addressing a group of health workers. In other words, the professional worker seeks to use consciously and purposefully rather than "instinctively" such tools for working with other people as experience and study can place in his hands. When our methods of work are clear, we are able to make an evaluation of progress, to describe our methods in discussion with other agencies and so reach a basis for cooperative effort with a family or project, and also we are able to teach other nurses who are young in the field.

Nurses who have had opportunity for considerable academic work often say that they do not feel sure they can apply to the actual job what they have learned. There is some real basis for this feeling, in that appropriate field work is not always available. Agencies and areas are only beginning to have enough nurse mental hygiene consultants, who, it is hoped, will little by little give us additional security in our work with people. Generalized supervisors, who are an essential link between administration and specialized consultants on the one hand and staff nurses on the other, are so overloaded with work that they cannot give the necessary attention to the individual nurse, and they have not always had as much preparation as they would like in mental hygiene methods and skills. By degrees, however, better education, better organization, and better understanding of our professional needs are helping nurses to meet the prob-

lem of relating what we know to the needs and capacities of the persons we work with.

What we sometimes fail to realize is that everyone—no matter how expert—feels somewhat inadequate when he tries to work perceptively with people. Probably this is a good thing, because if one could feel one “knew all the answers,” the need for a partnership of some kind—some degree of relationship with the patient—would not be so obvious.

It seems to be generally true of nurses that we have a deep fear of making mistakes. It is easy to see how this began and why it has grown in some cases to hampering proportions. The young student nurse works in a setting where disability or pain or death threaten many of the patients whom she is nursing. Even though she is safely supervised, this has an impact on her and she does not always receive the kind of help that would let her understand, and accept as normal, reactions such as pity and fear. She has to be absolutely accurate in her nursing care, and always in the hospital setting of heightened tension. A little mistake—a momentary lapse—could lead to wrong medication. We have spoken previously of the slow growth of a relationship, of the complicated nature of cause and effect. But in the hospital many procedures must be carried out *stat.*, and cause and effect often seem immediate and simple. For example, the immediate use of oxygen may permit the patient to continue breathing. As a matter of fact, though many nurses are not aware of this, we are legally responsible for mistakes in nursing care, even though we have been carrying out physician's orders. Most nurses are able to meet this demand and without too much tension. But it influences us nevertheless.

Later in her professional life the public health nurse also meets emergencies, though not all situations that seem to be emergent prove to be so. Each of us works as a member of a health team, but a baby or a hemorrhage or an accident will not always wait until the team can be collected. Sometimes the nurse has to make an immediate decision and take action as she did in her hospital days. In spite of the safeguards of standing orders and definite statements of agency policy, she must carry a heavy responsibility. Many people, including most parents,

encounter such emergencies, and must cope with them as best they can and endure them. But when the nurse is at hand or within reach, everyone, including the nurse, feels that she should "know what to do." Since the weight of responsibility is so great and the tempo at which she often works is so swift, it is not strange that in some instances she has found it hard to go more slowly and discriminatingly and has felt uneasy about her ability to do so, and about her methods.

Mental hygiene, however, would never be of any use in a vacuum. Knowledge of human behavior is useful only when it is "hitched" to everyday life, to other specialized knowledge, to organization and administration. Far from feeling insecure because there are new materials and skills to be learned, the nurse can gain steadiness through the realization that she already possesses information and skills so valid that new concepts and methods as they are acquired can strengthen and enliven rather than replace what she already knows. This is not to say that we do not have to re-examine our professional information constantly to correct it as new developments become known, or as we recognize that through personal bias we may be hanging on to a favorite bit of health teaching material that is no longer useful.

### THINKING THE SITUATION THROUGH

It would help us to attain added security and success if we could develop a more consistent method of approach to our problems whether these have to do with an individual patient, with a family or other group, or with a community project. In the old days, "approach" meant to us the various appropriate ways in which we might best make contact with the patient. Now we are seeing that it applies also to problem-solving. A clearer approach to our problems in general, puts all our work on a firmer basis, because we can think through afterwards what has been done, and explain it when needed. Much of the previous material has had to do with catching the feeling tone of a situation, and we have discussed the dangers of working and teaching only on "the intellectual level." However, we would all agree that careful, disciplined thinking is essential.

When we approach any situation we have in our possession a certain amount, often a considerable amount, of knowledge, skill, and experience. This consists of bedside techniques, knowledge of illness in general and of specific illnesses, material regarding health in general and ways of promoting it, a growing body of knowledge of family relationships and child development; often, too, knowledge of administration and community organization, and certainly of community resources. We might call this body of knowledge and experience our professional "backlog," or what is usually known as a "frame of reference." We cannot have all this information in mind at any given moment; nevertheless it is on call when needed, or we know where we can secure it. This body of knowledge is as little as possible contaminated by partly-understood information or by residuals of personal ways of doing and thinking of whose origin we are only dimly aware.

This backlog consists in a knowledge of what is "normal," as we currently see it, for our society. We are able, without applying too rigid standards, to compare the given patient and family or other professional situation with a norm. For example, it is considered "normal" for a biological family to consist of a father, a mother, and their children. If the family is not made up in this way, we take note of it, and of its possible meaning in the particular instance.

Similarly, we know from experience something of what a "normal" relationship between patient and nurse is like and, within the range of individual differences, something about the rate of movement we can expect. If, for example, after we have known over a period of some weeks a patient who is a married woman and she has said little or nothing about her husband, we take note of the possible significance of this, since as we compare this behavior with our backlog of experience in a contact of this length, the omission is not usual, and suggests difficulty where her husband is concerned.

As we enter a situation and try to establish in our minds a working diagnosis of basic factors and patterns so that we may fit ourselves into them, we try first to see the broadest, most pervasive factor in the situation, and to apply to it the general information we already have.



For example, it had been established in conference in a nursing agency that an adolescent girl, aged fourteen, was the only person in a household who could be taught to give an insulin hypodermic to a mother unable to give this to herself. It was finally decided to give her this responsibility. It is true that this girl was known to have considerable ability. But in considering the problem of giving responsibility to an adolescent, the nurse does not base her decision only on an evaluation of his character. She first thinks to herself, "What do I know about adolescents in general and about the assets and liabilities of this age group?" She finds that she knows a great deal about them and her knowledge is useful at this point. She knows that children of this age cannot maintain themselves at the peak of their maturity — that sometimes they act like adults and at others revert to childlike behavior and that this swing is unpredictable. She also knows that the adolescent is beginning to grow away from the authority of the parent while at the same time needing the protection of the parent very much. At some time in the future a son or daughter may find it necessary to reverse the roles of parent and child completely and take care of the parent; but usually this time has not yet come at adolescence. In making a mother dependent on an adolescent daughter for insulin injections we consider whether we are forcing this change of roles upon her in a harmful way. We also know that adolescents are far from sure of themselves, and yet we are about to ask a young adolescent to have the poise and controlled manual skill to insert a needle and give the medication. Some of us remember that it was not easy for us to give our first hypodermic though we were older than this child. She may be afraid of hurting her mother; she may even have the anxiety that comes from unconsciously wanting to hurt her and having to suppress her feeling because in our society it is forbidden to "attack" one's parents. On the other hand, adolescents like to accomplish seemingly difficult feats and to gain the satisfaction of behaving in an adult manner. Also, they still can be helped and strongly supported by an adult who understands their difficulties and respects their growth. Most nurses know this and more about adolescents; they only need to pull their information together. And this is what the nurse did with regard to the particular adolescent referred to above.

The next step in the process of making a working diagnosis is the "sizing up" of the specific patient and family situation and, as we know, no two are exactly alike. We realize that we can never generalize about any situation. We must evaluate each one on its own merits by observing and listening. At the same time that we are observing, we are, by taking purposeful thought, putting together the pieces of what we see and hear and noting the significance of omissions. We realize that all this may well have a meaning for our professional eyes and ears that is not apparent to the patient who is so closely involved. When a tentative picture of the particular patient and family is gradually put together in our minds, it is unique, not entirely like that of any other individual or family.

It is not enough in solving a jigsaw puzzle merely to lay as many pieces as we can find face up on the table. A picture has certain emphasized features, perhaps a central figure that shows up almost at once and that suggests what fits belong together. So it is with the picture of the patient or the family. We can say, on the basis of the general information we have at our disposal plus the specific observations we have made, that the patient's situation has a *focus*, which our thinking tells us may change but which we must see clearly if we are to respond with appropriate nursing care or teaching. Otherwise, we may have a partial view of the problem and miss the meaning of the total situation.

A young mother whose husband was away in the Army showed great concern about certain physical symptoms in her baby, and also about his rate of development. Several physicians and also a psychologist examined the baby as he grew older. Somehow the result of the physical examinations was not made clear to the mother, nor was the normality of the child's development as revealed by psychological testing. Yet, since this mother's anxiety — much of it justified under the circumstances — was apparent, it would have been possible to see that this was the underlying cause of the family problem and, as such, the major concern of the nurse. In thinking this situation over later, it seemed to the nurse that she could have helped to strengthen the mother's tie to a reliable physician or clinic of her own choosing, and could then have assisted her to pull together and understand

the medical care recommended. As it was, the situation was unfocused — and was vague and dissatisfying to nurse and mother.

All this goes to show that the nurse has a responsibility to make a working diagnosis of patient and of family, as individuals and in relation to each other and their environment. Some of us have shied away from this responsibility and it is easy to see why this is so. Medical diagnosis belongs to the province of the physician and we know from our first day as a student that the nurse does not "diagnose." In hospital training not all of us were helped to see that the nurse can make an estimate of the patient and his situation and needs to do so. We may perhaps have acquired the idea that social workers were equipped to make such social diagnoses but that we were not. It is true that the more knowledge of human behavior we have, the more skill in working with people we can acquire and the more reliable our thinking will be. Nevertheless, a conscious attempt to arrive at a working diagnosis of the patient's situation is safer and more practical than cloaking from ourselves the evaluation we inevitably make.

The following illustration shows how the use of our backlog of information and the study of the specific factors can bring a situation into focus:

A nurse had been going into a home for two weeks giving care to an elderly Italian whose diagnosis was inoperable carcinoma of the rectum. Medical orders included general care, cod-liver oil ointment to decubitus areas, and medication for restlessness and for severe pain. The patient was incontinent. His condition was very poor and it was not expected that he could live longer than a few weeks.

The home was a third floor apartment in a tenement area of the city. It was adequately furnished and was kept immaculate by Rose, the daughter.

The patient's wife had died ten years previously, also of carcinoma. The patient was a retired foreman, living on a pension, proud of the work he had done and of his long and faithful association with his church. The daughter, Rose, the only other member of the household, was described as an attractive unmarried woman about forty years old. (The nurse also described her as an "old maid" with the verbal explanation that she did not think of all unmarried women of forty as belonging in this category.) She gave instruction in metal work in the home to add to family finances but was unable to do this at the time because of her father's illness. Of the relationship between Rose and her father the nurse said, "Daughter seems determined to see her father through to the end though she rejects care of him. Tension noted between patient and Rose. VN feels that the

patient should receive daily care from the nurse. At first nurse tried to make some plan for care by the daughter during the rest of the day but due to poor prognosis, tension between patient and daughter and daughter's failure to take responsibility, nurse has not pressed this point."

The nurse further explains the patient's attitude as follows: He had not been told that he had carcinoma but had expressed to the nurse his feeling that he could not be cured. He seemed to long for the end. He had little money left from his earnings and asked the nurse anxiously whether they could be thrown out on the street. He told the nurse of dreams in which the daughter was unkind to him. It seemed to the nurse that while the tension between the two was realistic enough, the patient was irrational at times.

With regard to the care given by the daughter the nurse said, "Daughter says she gives constant care to patient but nurse believes she does very little but feed him and give bedpan. She has been known to leave patient on bedpan all night. She was very lax about giving medication other than narcotics and has ignored VN's instructions to turn patient from side to side to prevent further breakdown around sacrum. She found bed care difficult to give. Daughter states she does not go near patient any more than is absolutely necessary because it upsets patient and herself. A friend comes in sometimes during the evening and gives partial care."

This situation shows the danger of making a partial, or too superficial, working diagnosis of what we see and hear. We may say, for example, as was said in the staff conference where this case was discussed, that a poor father-daughter relationship existed. This is true, but it does not go far enough. Again, it could be said that the daughter was a repressed individual who was embarrassed by the type of nursing care necessary. This seems to be true, too, but again it is a partial explanation.

A suggested focusing of this case, built on information we possess plus observations in the particular home, is as follows. We seem to have here not merely a poor father-daughter relationship, but something much more basic—a father-daughter relationship in general, some aspects of which were normal and some abnormal. An age-old law of society forbids physical intimacies between father and daughter. This prohibition is bred in our bones and cannot be entirely forgotten even under extenuating circumstances such as the need for nursing care. As a result many women, especially those not trained as nurses, will have difficulty in giving intimate physical care to their fathers. The case of Rose has been discussed with many nurses. About half of them thought they would have difficulty in giving such

care as was required of Rose to their own fathers. In other words, part of the difficulty in this home is based on a normal reaction on the part of the daughter, inherent in every father-daughter relationship.

This situation also shows us that the nurse was in some difficulty because of her own emotional reactions to what she had seen and heard. With her thinking colored by her concern for the patient and her dismay at the daughter's attitude, it was hard for her to see that the daughter, with all her possible faults, was actually in a very difficult position. Had she thought through to that fact, she could have said to Rose, "I can imagine that you may be embarrassed at having to care for your father. What parts of the care can you do, and which do you find you cannot do?" It seems reasonable to think that planning the efforts of the nurse, Rose, and the neighbor could have followed; that some of the unhappy realization that she was not giving good care to her father could have been lifted from the daughter, perhaps even with a lessening of the tension between the two. It can be seen that if this had been a patient with a long-term rather than a terminal illness, it would have been even more important for the nurse to understand and focus the situation in some such way.

An additional point that can be noted from the above illustration is the importance of recognizing the strengths an individual or situation may have. Some of Rose's difficulty in caring for her father is "normal," for instance. Also she is a woman of some talent, and an attractive one, too, to name the assets that are most obvious. It is interesting that as we begin to gain some skill in analyzing situations, it is first the weaknesses and abnormalities that seem to stand out rather than the strengths. This tendency is not limited to nurses. Helen Harris Perlman says, in an article on teaching psychiatric social work, that the social diagnosis (or what we have called the *working diagnosis*) "is the study and appraisal of those factors in the individual's social situation which affect or can be used to affect treatment, and of those adjustments and adaptations by the individual himself which bespeak the health and strength in him."<sup>21</sup> Such a positive approach, she continues, "is needed to counterbalance the tendency which grows in the student, as he delves deeper

into psychiatric literature, to recognize only the pathology of the individual." There are several reasons why it is easy for us to note weaknesses and difficulties in our appraisal of a situation. For one thing, history shows that medicine has been developed through the study of the abnormal. Our association with medicine naturally leads us to look for signs of ill health as the first step toward promoting health. For another thing, we may not yet have entirely sorted out in our minds what is "right" morally or desirable professionally from what is "strong" in that it reveals the potentials of a particular individual. For example, it may be hard to realize that marked hostility to the nurse on the part of the patient can be an evidence of the strength of his personality, even though this resistance hinders at first the establishment of a helpful relationship with him. At least, it shows that he can gather himself together and follow his own course of action.

### OBSERVING

"Observing," "listening," and "responding" are skills which all feed into the thoughtful process of problem-solving, and are the means, other than bedside procedures, by which the nurse keeps in contact with the patient. They have been described so well by Annette Garrett, in her book *Interviewing: Its Principles and Methods*,<sup>43</sup> that they need be discussed here only as they relate specifically to the work of nurses. Each of the three skills will be considered separately, though actually all take place concurrently.

Nurses are trained observers of bodily symptoms. In the early days they were particularly concerned with symptoms of illness, but recently they have also acquired the ability to observe the signs that mean health and vitality, both those which are there for us to see over a period of time, such as the nutritional state, and those which we must catch as they come and go as, for instance, the way a person moves or his gestures. Because each of us was originally trained to note and to report symptoms, rather than to interpret them diagnostically, we have an extraordinarily good start on objective evaluation. As a result, there is less chance that we shall try to interpret what behavior means before

we really have observed it. As we develop our skill in observing, more and more of the patient's behavior becomes significant for us.

The professional worker is unconsciously selective in what he sees and fails to see, and no one can observe, remember, and record all there is to be seen. Even so, we can still fill in the picture with more detail than we sometimes do. What, for example, is the basis for the "bunches" that we have about people and that the experienced nurse as well as the experienced physician often finds to be accurate? This clinical sense in many instances derives from half-remembered details in the behavior of the patient which the professional person has put together in his mind without being fully aware of doing so. If we are more observant of these details at the time they occur, our clinical bunches become reliable sources of information and we escape the danger of unconsciously identifying a patient with someone else, just because the two are vaguely similar, and thus missing his unique quality.

The meaning of the patient's behavior is often quite obvious. When a mother continues her ironing during the nurse's visit or does not offer her a chair, the nurse can usually take it to mean that she is unwelcome. One mother had a way of talking baby-talk loudly to her baby when the nurse approached a certain subject, a hint that the subject was painful to her which warned the nurse to go slowly at this point. Other behavior is less easy to interpret. One mother, who had been unable to pay the nurse for a formula demonstration, did pay her in full on the next visit. She did not attend child health conference as she had agreed to do, and when the nurse next visited the home she was not admitted. The nurse realized then the real reason why the fee had been paid — she had quite literally been paid off and her services were not wanted.

Not only what the patient does, but when he does it comes to be important to the nurse. Experience shows that the patient's behavior at the beginning and at the close of the contact is often revealing. For example, does the patient who comes to clinic settle in easily, opening his coat and greeting the staff readily, or does he guard himself and his possessions stiffly? It

is easy to see that either type of behavior is symbolic of the way the patient feels in the situation.

We are beginning to see that what the patient does *next* is all-important to our contact of the moment and our ultimate grasp of the situation. In every contact we have cause and effect operating, a process going on; there is a close relation between what has just been said by patient or nurse and what the patient says or does next. It seems inevitable that sooner or later our records will be written so as to reflect this process more accurately.

It is difficult for us to understand a patient when we see him only at moments of crisis. Is his behavior at such a time characteristic, or is it an exaggerated response to a highly charged emotional situation? We can only answer that question if we have seen him when his life is normal and he is behaving in his customary, everyday way. Our own behavior, too, is affected by emotional strain. If we are upset or disturbed, our first impression of a patient may be colored by our own feelings and our idea of him may become fixed or distorted.

Often, if we reread our records, we find comments that show unrealized bias in our observation. A very skilled nurse was helping a family and the physician to arrange hospitalization for a young mother who had become psychotic during her postpartum period. She said on the record that the family was "surprisingly unemotional" over the illness and the necessary commitment. Yet the patient's parents and an aunt were helping in the home, the husband was taking responsibility well, they had asked for and were using the help of the nurse, they were gentle and kind with the patient. However, they were not going to pieces themselves. The nurse, on thinking this over, said that either she had become accustomed to excitable, uncontrolled behavior in the area where she worked, or that she herself still felt without realizing it that such hospitalization was a tragedy, and so had expected uncontrolled behavior on the part of the family. Recently a psychiatrist who had been treating a small child through play therapy said in staff meeting that the child was working out some "fascinating" phantasies in his play. The distinguished psychiatrist who was leading the discussion later came back to this statement and asked why those phantasies were



particularly fascinating. It was hard then to explain on any acceptable basis why those aspects of the child's behavior were of any more interest than others. We all have some such personal bias. It is "fascinating" to see it in ourselves and to learn to guard against it.

We are learning to be more exact in observing the behavior of the patient who is a puzzle to us. When a nurse writes on her record, "Mother is a very strange woman," she is unequipped for her next meeting with this patient, and anyone else who reads the record is in the dark, for behavior that is "strange" to one nurse may be commonplace to another. One record states, with regard to a situation in which nurse and mother were not developing a working relationship, that the nurse "cannot make out the mother's attitude and what kind of person she really is." Perhaps this nurse was wise to be puzzled. On the other hand, perhaps she could have helped herself by further careful observation: How does the patient look in terms of the signs and symptoms of health which we well know; how does she dress; how does she take care of herself and is this appropriate; how does she move when she lies, sits, stands, or walks; what is the rate, amount, and kind of motion; how does she act in relation to the physical environment, in relation to the people about her? We may find that such observable facts are new pieces to be fitted into our puzzle.

We now realize how important it is to observe relationships with other people. The way in which two or more people in a family get on together is as significant as the particular role each assumes as an individual. The muscular tension of a young mother may make it difficult for her to feed her baby and this in turn makes it difficult for the baby to eat. In this way a spiraling difficulty is set up in the relationship between mother and baby which the nurse can see and in which she may be able to intervene. Years ago, when this book was first written, the importance of the "key person" in a family was emphasized. Although some one person in the family is usually the individual whom the nurse knows best, we no longer give all our attention and effort to understanding and helping him, no matter how significant the role he seems to play in the family. Now we are coming to realize that all individuals in a group such as the

family strengthen or weaken one another and that if we are to understand the individual we must observe the family as a whole and the interaction among the members. Perhaps we first began to understand this when we recognized the difficulties and opportunities facing children in the same family and realized that we must see these children not only as individuals, but in relation to one another.

Another area of observation is especially important to our preventive function. This is the growth and development of babies and small children, again not only as individuals but in relation to other people who surround them closely. Our backlog or frame of reference is important here, and we either have, or must somehow acquire, the most accurate, careful, and specific data currently available on the ways in which babies and children develop — both physiologically and in the allied consecutive phases of their need for and relation to other people. Few of us have sufficient information of this kind though we realize we could use it many times a day. Not many courses offered us in child development give us adequate technical material relative to physiological and psychological growth. We already have an excellent basis on which to build, as shown by our developmental histories of infants, which are often invaluable and may be the only objective record of the individual at that age. Their usefulness has been proved again and again in case conferences among agencies. Our work with infants and children is an area into which much of our nursing time goes, and one in which our observation could be greatly strengthened by further preparation.

### LISTENING

To the nurse "listening" is a familiar activity, for many people have felt a need to tell her their problems or their interests and plans. But it is also a skill, and the nurse is learning that she can make it professionally purposeful without losing any of the friendly sympathy that makes her so easy to talk to. One supervisor said of a nurse that she listened with "sympathetic reality."

People may talk to us because they need the relief or satisfaction that comes from sharing fears and anxieties or successes with an accepting person, who is not part of their situation yet

understands what they are talking about. We realize that the patient at such a time is not seeking advice from us and that it is quite possible to listen without offering advice. Also we have learned that it is not "good" for all patients to talk to us in this way. A patient who has built up an unhealthy point of view as a defense against his difficulties may want to state it to the nurse again and again, using her as a sort of sounding board in order to strengthen his convictions. We saw an example of this in a previous illustration when the nurse was expected to listen to a man and wife who tried to out-talk each other. We have learned not to batter down such defenses since the patient may have no better ones at the time, but we have also learned not to let the talk go on too long. Patients often talk to us volubly because they are avoiding a subject that is important to them but that they fear to touch upon. In such instances we try to "wait it out" quietly, knowing that often there will come a pause, followed by some briefer indication of the real difficulty.

We have known instances when patients have told us more than they expected to tell us and have regretted this later when they were calmer. Then they may feel embarrassed with the nurse and reject her because they consider that she knows too much about them. We have learned to block off such confidences, or at least to help the patient to understand that we are glad to listen, but only if he really wants to tell us.

When we have listened to a patient who has talked very freely to us, the question may arise whether we have a right to use this material. Perhaps the patient has said, "I am telling this to you, not because you are the nurse, but because you understand the situation as a friend; you see what goes on." Such a remark from the patient may mean that he is really beginning to sense the non-judgmental attitude of the nurse and is no longer thinking of her as representing authority. Probably we cannot expect the patient to have a clear idea of the professional limits of a relationship and it will only confuse him at this point if we try to explain to him the difference between being "just a friend" and being a friendly nurse. So, if it seems wise, we hear him out, believing we can do so with integrity because we shall use this material to gain a better understanding of the

situation ourselves and to lead the patient to a gradual realization of the function of the nurse.

Some nurses are in considerable conflict about recording material which the patient has labeled confidential in this way. If we keep adequate records so that this more bizarre material does not stand out startlingly against a meager background, and if our records are safeguarded according to professional standards, most agencies expect such material to be recorded. It belongs to the agency, not to the nurse. If we hesitate to record material even when records are properly guarded by the agency, it may be that we do think of the patient's confidence as a personal gift which we do not want to surrender.

It may happen that a nurse tries to block off confidences that are painful to the patient because she, too, has had painful experiences, perhaps somewhat similar ones, and has not yet learned to fit those experiences into her life and to use and accept them. When she gains better perspective she no longer needs to guard herself against hearing and seeing the troubles of others and, without developing the "shell" of which we are sometimes accused, can combine her own growing steadiness and understanding of life with sympathy for the patient. As Dr. Lemkau put it in talking to a group, "The nurse is not always the lucky possessor of fancy techniques but is secure enough so that she can listen to the emotional problems of others."

A great deal is said about "respect" for individuals, and about the manner in which we should listen if we have such respect. The word "manner" is used advisedly because sometimes "respect" is confused with "politeness" based on social custom. For example, one may listen to a much older person "respectfully" without interrupting or giving any sign of being uninterested because we have been taught from childhood that this is the thing to do. With a friend of our own age, we may "listen" without interruption but may really be thinking of the much better story or experience with which we shall soon cap what he is saying. Or we may wait until we have a chance to repeat our point without being influenced by what our friend has said in the meantime. Other people do the same thing to us. Sometimes it seems that it is the rare person who has the kindness, security,

and interest in others to let his own needs for expression go till another day while he really listens to what a friend wants to say. Many times we do not listen with "respect" for the individual in any vital sense.

At times this is because it is difficult to get past the stereotype of the first impression. An unkempt woman working in a disordered kitchen may mean one kind of person to us; a woman scolding a child may mean to us a certain kind of individual; a foreign-born man, from a culture where speech and gesture seem more violent and explosive than ours, may fall into another familiar category. But as we listen to these people talk and watch them, their individual personalities begin to appear, though their ways of behaving, thinking, and getting along with people are perhaps quite different from those to which we are accustomed. As a professional group we no longer seem to need frequent warnings against too direct questioning of patients in order to get material on records promptly and completely. We have outlived the days when it was appropriate to caution us about the importance of listening to the patient. However, some of us have yet to experience the full satisfaction and interest of seeing the special personality of the patient emerge as we observe and listen. We know the importance of respect for "the rights of man." In our day-by-day work we may find that respect for individuals and groups is even more compelling as their ways of behaving become slowly clearer to us, and as we learn to appreciate their uniqueness.

On the other hand, the nurse may represent a stereotype to the patient, and be identified by him with some previous experience. When the nurse is confronted with the reaction of the woman who opens the door to her, in whose living room or kitchen she sits, or whom she meets at clinic, it may be difficult for her to understand that the patient's behavior is a response not only to the immediate situation but to other similar past situations, whether remembered or not. Built into her reactions are happy or unhappy experiences with people in this country or in the culture of another country, fulfillments or frustrations, and family relationships that have led to the growth or deterioration of her personality. She may be cordial or suspicious, inter-

took place prematurely without medical attention or the preparation of supplies.

The nurse then went into the home to give needed bedside care to mother and baby, a physician having been called following delivery. The record states that the patient "resisted everything which the nurse wanted to do for her" and that the nurse felt no progress could be made under existing circumstances.

Presently the local factory reopened and the man was re-employed. Family tension was immediately eased. The nurse found herself more acceptable since she was no longer linked in the minds of the parents with an unkind authority. The record shows that the mother obtained a postpartum examination and in other ways welcomed the services of the nurse.

This is an ordinary enough tale, cited partly because the files of every nurse contain its counterpart at almost every point. With this family as with many others, the nursing function was hampered by the emotional reactions of the parents established over a period of years. As often happens, the final acceptance of the nurse by the family came about apparently through a circumstance controlled in this instance neither by family nor by nurse — the re-employment of the father. Sometimes, when progress is due to a factor the nurse has not helped to introduce, she feels deflated because the improvement "would have happened anyway," but in this instance the nurse took advantage of the altered circumstances. The main interest of this story, however, lies in the probability that the relationship had little or nothing to do with the approach used by the nurse. She was unwelcome because she offered antepartum care for a pregnancy that was undesired and because she was identified with the relief agency and thus with the parents' unanalyzed misery over their situation. She represented adverse authority in spite of herself, and everything she said was rejected in early contacts. Baffled and exasperated as she was, the nurse was able to recognize and accept the factors that underlay the family's reactions.

The fact that professional workers have seen the relief that patients gain from talking to them and the ability to reorganize themselves that sometimes comes as a result, has led in years only recently past to some peculiar ideas about the technique

of listening. For instance, it was thought desirable and possible almost to blank oneself out of the picture as one listened. There have been various overinterpretations of this "passive technique." Realistically, however, the nurse is part of the picture. If she tries to eliminate herself, it is possible that the patient will interpret her attempt at psychic withdrawal as lack of interest and therefore as rejection. We have learned to control dismay, or too much sympathy and pleasure, as we listen. But on the other hand, we need not be afraid to let our warmth and interest be obvious.

As a matter of fact, while we are listening quietly or as we carry out nursing procedures, we are really accomplishing a complicated mental process. With no lessening of interest in what the patient is saying at the moment, the nurse is observing him carefully as he talks, noting what part of the material comes easily and what comes after pauses or with difficulty; what the patient does not say but which the nurse knows from experience many people would say in that connection; what subjects seem to follow one another in the patient's talk and why these subjects seem to be related in the patient's mind; whether what the patient says seems realistic in the light of what the nurse knows about the situation or whether the patient seems to be taking refuge in any of the other dynamisms of behavior that are increasingly familiar to us. For example, he may be denying an obvious fact or emotional reaction, or projecting his own feelings onto another person. At the same time the nurse is constantly aware of the "what-happened-next" aspects of the visit. When the visit is over, she finds that it takes no feat of memory to remember what happened during the visit because this coordinated, cause-and-effect observation and listening has recoverable consecutiveness. The events of the visit hang together. They can be picked up and wound or unwound like a ball of yarn. A verbatim memory is not required — only a way of working that, with time and practice, becomes habitual. We cannot always know *why* a patient said a certain thing during a visit or in a group, but we can know *at what point* he said it — what was said or what happened before or after — and so preserve the part that puzzles us for further study and for clarification when we know the situation better.

## RESPONDING

Responding seems to be of most concern to nurses at the present time because it is a skill about which we feel less secure than about observing and listening. Many of us feel that responding is synonymous with "interviewing techniques" and that here our preparation has not been adequate. Although we have outlived the days when we expected to have a set of rules for understanding human behavior in general, it may be that some of us are in this phase when it comes to appropriate response. We sometimes want help in knowing exactly what we shall say to patients in a face-to-face situation because our training makes us alert to the danger of making mistakes and harming the patient and so we are afraid we shall say the wrong thing.

No ready-made tool will help us to use this skill — no phrase book of appropriate responses. The response to be made — the comment or the answer to a question — depends on all the other skills and attitudes discussed, some of which are summarized here: the nurse's understanding of the dynamics of behavior — that the patient has conflicts not clear to himself and because of them has built up various defenses which enable him to get along more comfortably; the use of her backlog of professional information and experience; her knowledge of the specific situation; her attempt to think it through and to focus it; her evaluation of the patient's strengths and weaknesses; and her awareness of her own feelings and reactions. If our fear of "saying the wrong thing" is based on the realization that we do not habitually take into consideration all these factors when we visit a patient, our unease is logical enough, but it is a helpful kind of fear in that it may make us work with increasing thoughtfulness.

There is probably no one right way of saying things under all circumstances. There is no doubt that people can misunderstand one another's use of certain words. We all have sat in staff meetings or interagency conferences where we seemed to bog down in definitions of terms. Probably we would agree, however, that the better our basic understanding of one another, and the clearer our common purpose, the more easily we find words that are clear and satisfactory to everyone, whether in staff conference or during a visit to a patient.



One rural public health nurse had been brought up in a family where the phrase "cunning little monkey" as applied to a baby was a term of affection and admiration. When this nurse used the words to describe a baby in a home she was visiting for the first time, she was startled to find that the mother resented it and felt insulted. The nurse realized she had said the wrong thing and it was difficult to iron out the misunderstanding.

In a clinic situation, a physician and nurse were working with a patient whom they did not yet know well and who later proved to be very neurotic. The physician said, "We want to be sure to check the blood pressure." Actually, the apparatus had been removed to another cubicle and the physician was reminding the nurse to have it in readiness before the close of the examination. The patient, however, seized upon this comment and on later clinic visits expressed anxiety about her blood pressure, which was normal and which had caused her no concern previously. This is allied to the anxiety experienced by even well-adjusted patients who overhear or think they overhear a comment on their condition not meant for their ears. All of us can cite examples of words that we or others have used with unfortunate results.

By and large, however, an aside like the above does not begin to have the importance of a verbal response that is "right" or "wrong" because of the nature of the feeling or understanding behind it. In fact, although two different people may use exactly the same words to another individual, from one the words will be acceptable and helpful, while from the other they may seem blunt and startling. Our verbalizations depend somewhat on our own personalities. Some nurses are outgoing and quite direct in what they say. Others are more retiring and more cautious in speech. Since we no longer insist that all bedside procedures shall be done in exactly the same way, provided that the comfort and safety of the patient are assured, it would seem logical to realize that we need not all make verbal responses in the same way, so long as each one is disciplined and purposeful in making her responses.

Again, though we hope not to make too many mistakes in talking with people, we can bear in mind that human beings are resilient and are not usually injured to any alarming extent by something we say that later seems to have been unwise. If that

were not the case, the method of training psychiatrists and social workers by which, as students, they are alone with a patient in an interview, would be too dangerous to be justifiable. Here again, however, we have the complexities of our function to consider. On the one hand, as we work with a tense young mother who is telling us her feelings about her baby, there is no formula for our verbal response; but if we are showing that same mother how to measure and give a medication which the physician has left for that baby, we are and must be absolutely exact. Is it any wonder that the first skill may seem "vague" to us in contrast to the other; or that both may seem to require similar precision because we feel lack of precision will leave a bad effect in any situation?

When she gives nursing care in the form of prescribed procedures, though the nurse must use her judgment, still she knows she must take responsibility for carrying out the procedure if it is at all possible to do so. On the other hand, situations which do not involve specific nursing care can go fast or slowly as the case may be, and depend less for their tempo on the active initiative of the nurse. As we think this through further, it seems clear that while we are called upon to work in different ways in different situations, no actual disparity of method exists but rather a need to suit the method to the situation that confronts us. The apparent disparity has influenced us in the past. However, less and less do we feel now that we are functioning differently on the days when we say to ourselves, "Today I am going to do 'health supervision'" from the days on which many public health nurses have a schedule of bedside care.

Soon the importance of this "split" may fade away as did one that previously puzzled us: is the nurse two different people, one the professional person on duty, and the other the personal self off duty? Now the nurse realizes that she is one person, behaving appropriately in different situations.

If there is any one aspect of our contact with patients that can safeguard our verbal response, or endanger it, perhaps our handling of our possible identification with a patient, or with another member of the family, is that aspect.

The nurse may identify, with or without realizing it, with one member of the family who appears to warrant special sym-

pathy and protection, or with a faction in the family. Sometimes circumstances seem to point to one person as so obviously "right" and to another as so obviously "wrong" that the nurse unhesitatingly allies herself with the "right" one only to find later that neither could be said to be wholly right or wholly wrong. By that time the damage may have been done so far as the relationship of the nurse and family is concerned, for the identification with one member of the family will then not permit acceptance of the nurse by the other member.

Often the erroneous idea we form of a member of the family who is unknown to us may result from a projection of the feelings of the member whom we do know. For example, a wife reported her husband as being unwilling to have the physical examination his condition apparently indicated. She described him as a prejudiced, violent man whom the nurse would not like to meet. A subsequent notation on this record states, "Nurse has been in touch with father who does not seem as difficult as he has been pictured." It is hard to know how to proceed in such instances. Obviously, the mother did not want the nurse to work with the father. Whether the state of affairs will be helped or hindered if she does so is a matter that the nurse has to think through in each given situation. It is often a choice of two evils—to risk failing to establish any working relationship with the family, or to establish a relationship with one member who does not use it constructively.

The following suggests an understandable, though unfortunate, identification on the part of the nurse, in this instance with members of a family who showed a united front against the father, an extremely disagreeable man who never had been able to support his wife and children. The family had been known to a large number of social agencies including the family agency, the settlement house, and the visiting nurse association. It is easier to look back over years of work and recognize errors in judgment and in methods of work than it is to plan to avoid them. Social work and public health nursing appear to have been making such rapid strides toward more constructive methods of work that the mass alliance of several agencies with certain members of a family against another member may never again

be possible. At any rate, from the beginning, the father had been considered ill-tempered and inadequate, and his opinion had never been sought by the mother or by the children as they grew older. One cannot say that the family situation would have been different if it had been recognized from the beginning that the man was a steady worker, perhaps to the limit of his capacity, and that he had a legitimate place in this household. No one can estimate how much of his consistently bad-tempered behavior was the result of a painful awareness of his own failures. Possibly at the beginning of the contact with the agency a psychiatrist could have helped him and his family to a better adjustment. Whatever could have been done then, it seemed now too late to undertake it. Consequently, difficulties of long standing hampered the work of the nurse in this divided household. In addition, she may have set limitations for herself when she identified herself with the mother and children without adequate thought for the family as a whole.

Sometimes a nurse feels more at ease in working with the mother than with the father, and so identifies with the mother or overemphasizes the difficulty, often very real, of getting in touch with the father because he is away from home when the nurse calls. The anthropologist Margaret Mead made an interesting comment on the cultural aspects of the father's absence from the home during working hours. She points out that the accepted pattern for the way a man shall spend his Saturday mornings — when he works according to the current five-day week — has not yet been established. A new culture pattern is in the making here. She suggests that Saturday may come to be a time when the father becomes a part of family life to an extent previously denied him.

In general, we have been prone to identify with children rather than with parents. There was a time when professional groups seemed to be enmeshed in this identification, but now we are more realistic and see that parents, too, deserve some help and recognition! A number of professional groups, including our own, have varying degrees of protective responsibility for children. We go into a number of homes where the actual safety of children is the focus of our attention. However, when it is

considered safe to leave children in a seriously mishandled home, then our only hope of protecting them lies in the possibility that some of the feelings and methods of the parents can be better understood, even accepted by the nurse, and that a better working relationship can be established, even though the goals are very limited. One nurse had occasion to realize too late the extent of her identification with children. She said, "I held my tongue as long as I could but finally I couldn't stand it any longer." She felt that her verbal response here had been "wrong" in that when the crisis came, it was precipitated by her own accumulating feelings. The situation may have called for drastic action on the part of the nurse and others in the community, but nothing was bettered by the nurse's "correction" of the mother at that point, as the nurse herself was the first to see.

We can see a world of difference between using self-control to throttle a response and deciding not to be "active" at the moment. It is reassuring to know that more often than not we do not need to make a *stat.* response — that a visit or an interview need not be a question-and-answer affair, and probably should rarely consist just of an exchange of verbal responses between patient and nurse. Pauses can be just as useful as words and do not need to be uncomfortable, and the words that follow a pause are often all the more important. If the nurse is in doubt as to what to say and feels that she does not see the situation clearly enough to make a positive statement at the moment or to offer appropriate teaching material, she need not do so. If she must say something at that point, she can make a neutral response or ask the person with whom she is talking to tell her more about the subject. More often than we may realize, this is the best method of responding anyway, and results not only in our knowing more about the other person, but in helping that person to do his own thinking, aided by our friendly and strengthening presence. Then he may ask us for information that fits in with his thinking. If the nurse is for the most part a healthy, flexible, and knowledgeable person, the patient will tend to identify somewhat with her, whether or not he realizes it, but the nurse tries not to overidentify blindly with the patient. It was said previously that the nurse takes the leadership in this professional relationship. Here is the crux of responsibility for leadership. The

nurse knows that the patient learns through identification with her. She uses her leadership not to foster in the patient a dependency that will lead him to imitate the nurse, but to give him backing so that he can use what strengths he has and find the methods of behaving that are in line with his own personality and interests.

A part of our "response" that causes us concern — and may well do so because of its difficult nature — is "interpretation." Confusion can exist as to the activity implied in this word, the timing of any interpretation we shall give the patient, and the extent to which we shall interpret.

Often we are confused by a technical term and the skill it represents because it has several different meanings according to the situation to which it applies. When we understand this, our confusion is cleared up and we are able to use the skill as the occasion demands.

For a long time we have used the word interpretation to describe our explanation to the patient of the doctor's recommendations. We say we "interpret the doctor's orders." We also use the term to describe the results of our thinking about a patient's behavior. "I interpret Mrs. X's reactions as meaning so-and-so."

To these accustomed usages we can add the more technical current meaning. For instance, in the visit we make a comment based on our observation and knowledge which summarizes or clarifies what the patient has been saying to us, and which takes the patient a step further in his understanding of his situation than he could have gone by himself. This is interpretation. Implicit in it is the nurse's judgment that the patient is ready for it. If he is ready, much that has been confusing and bothering him may be easier for him; if he is not, he may become more frightened and anxious. His readiness depends not only on his own self-confidence but on the strength of his relationship with the nurse who is making the interpretation. If he has sufficient confidence in himself and if he has come to regard the nurse as an understanding person who takes him as he is, then he is ready for her clarifying comment. If we have any tendency to want to punish a patient or to gain a feeling of power because of knowledge superior to his, it is at the point of interpretation that we

may need to watch ourselves. It is not easy to wait and say "nothing" when we feel that we see the patient's difficulty clearly and that a "reasonable" explanation from us would make him see it clearly, too. We are learning that such interpretations are useful only when the patient as well as the nurse is beginning to see his situation more clearly and when we are sure that our decision to give the explanation is not tinged with desperation over slow progress or with irritation over the patient's behavior.

Clinical practice has shown that many times an interpretation in actual words is unnecessary. For example, a child who may be living through with the psychiatrist an experience in family relationships in which he is finding that the psychiatrist is a reliable adult (a "good father") and is working through with him his miserable feelings about his own parent, rarely needs to be told in words what is happening to him. In case material used in Part I of this chapter, a young mother told the nurse that she felt "more of a person." The nurse had been working definitely toward that end, but had no need to interpret to the patient the meaning of her words or the process that led to them. It has been said that a successful visit or interview or a useful relationship is like a dress rehearsal in which the patient is working out a way of feeling and behaving which he will then use "on his own" when the curtain rises on the actual performance.

There are other times, however, when the best judgment of the nurse tells her that some of the feelings of the patient and some of his behavior need to be brought out into the open. The patient just about to go to the operating room for difficult surgery may say that he is not afraid. Probably he is very much afraid and would be relieved by saying so. The nurse can bring this fear out of biding, at the same time justifying and diffusing it by suggesting that most people are afraid prior to an operation and that this seems reasonable enough, and adding the reassurance that may be appropriate to the situation.

A nurse had been having a difficult time in the follow-up of a woman with tuberculosis, a discharged sanatorium patient who was not keeping her return appointments for re-examination and was thought to be in danger of breaking down. The number of not-at-home visits was monumental, though they were interspersed with enough contacts with the patient to make the nurse

aware of the patient's fear and nonacceptance of her tuberculous condition and of the nurse. The nurse was uncomfortable in this situation and though she recognized the patient's fear of her and the illness, she tried to explain to her that the follow-up was a matter of "friendly interest." Could not the nurse have interpreted to the patient the feelings that were so obvious and so near the surface and in this way have brought some reality into the relationship? Suggested words, apart from the actual situation, always sound ridiculous and prove the fallacy of the "right word" learned by rote. But the nurse might have said, "You must be sick and tired of me and I don't blame you, and frightened about this tuberculosis. If we can get going on this, there is a good chance that we can clear the matter up and you need not be so afraid of tuberculosis, or think about it all the time." This is an instance in which the nurse could have "interpreted" the patient's fear and anger with the possibility of good results.

Subsequently, even though no such interpretation was given, the patient went to a chest clinic for x-ray, saying to the nurse, "I might as well get it over and done with." Then came the necessity to compare this x-ray with previous ones and to explain it to the patient. The nurse mentioned the name of a physician with whom the patient had had a number of contacts. The patient said irritably, "I don't know why the City always thinks Dr. X is my doctor." The nurse realized an indirect expression of the same fear and resulting anger. Instead of merely being patient and continuing with her discussion, she perhaps might have said, "I don't wonder that you are disturbed by all this; but we are further along than we were before."

Perhaps some of our difficulty in making interpretations, in instances where this is advisable, is based on the difficulty we have in accepting our own emotional reactions, with the result that we do not recognize the emotional reactions of others as natural under the circumstances, even though they may be hampering. Since the other person, too, probably has been trained to conceal his real feelings, he may need the reassurance that comes from knowing that the nurse understands and accepts his emotional reactions. Then perhaps he can trust her and they can work together.

The following case material shows the nurse observing, listen-



ing, and responding — also thinking carefully about what the situation holds but delaying interpretation until the patient knows her better. In this instance the father with whom the nurse was working finally made his own interpretation.

Herbert, at the age of two, had had an attack of rheumatic fever, which had apparently not been diagnosed so that he had not received the necessary medical treatment at the time. When he was three years old, he was hospitalized for a streptococcus sore throat in a city hospital in northern New England where it was discovered that he had had some earlier heart damage. When the family planned to move to another city, the family physician recommended that Herbert be placed at once under medical care there. Acting on this recommendation, Mr. B, Herbert's father, came to the public health nursing agency in the city to which he had moved. The nurse's record reads:

When Mr. B came to the agency he appeared nervous and ill at ease. I introduced myself as the nurse who had talked with him over the telephone the day before. I told him I was sorry his little boy was ill and I hoped that we could help him. I invited him into the office where he sat down on the edge of a chair.

He immediately began to talk, squeezing and folding his hat during the entire interview. He said he was not sure he was in the right place. He did not know he was coming to a welfare building when he started, but Mrs. S, a neighbor, had suggested we could help him. All this business was new to him and it was taking him a while to find his way around, and when Mrs. S directed him to our office he thought he was coming to the Red Cross nurse like the one he had when he was home in —. I then asked him if he had recently come to —. He said that was the reason he had come to us for help. I said he mentioned his boy when he telephoned yesterday. He replied that it was his boy he was anxious about. He gave Herbert's history of rheumatic fever. He then said that the family had moved here about three months ago, a month before Baby Roh was born and that Mrs. B had returned to — for delivery and he had taken time off to stay with his children as arranged when he took his present job. Herbie had been fine but had then caught cold while his mother was away. His doctor at home had warned him about the danger of infections for Herbie. He decided to call a doctor and asked his neighbor, Mrs. S, for advice. She always had the district service doctor but Mr. B did not want any charity and he had heard these district doctors were students and his Herbie was not the one they were going to practice on. "You can understand that, can't you, Nurse?" I said that I could understand he would want good care for his boy. He decided to call Dr. G about whom the grocery man had told him.

He did not like Dr. G. He was not like his doctor in —; he fright-

ened Herbie and Herbie refused to take the medicine. It was nasty stuff whereas his own doctor had given medicine that tasted like chocolate. "He charged four dollars and didn't even listen to Herbie's heart. He must be a quack doctor, Nurse, don't you think so?" I explained to Mr. B that some of the families we knew did have Dr. G and seemed to have confidence in him.

I asked Mr. B how Herbie was feeling now. He said the boy was listless, not hungry, seemed to be getting "paler by the day" and had many nightmares. He knew the boy was not well but would not call Dr. G again — not only because he wasn't any good but because he charged four dollars. Perhaps I could tell him the name of a good doctor in the neighborhood. He could afford two dollars — that was all his family doctor charged in —. He did not want charity and that was why he hated to come into this Welfare building. He did not have much money since coming here — it cost a lot to keep his family here — but he did have a chance for advancement and thought his children would have more advantages here when they were older. However, he had always tried to pay his way and wanted to do so now.

It was explained that the standard fee for most doctors in the area was four dollars for house calls and three dollars for office visits; that as an agency we did not recommend any one doctor, but we could give him a list from which he could choose. It was suggested that he could discuss his financial situation with the doctor he chose and make some good arrangement. Perhaps he would like to discuss this with his wife since she was to return soon. If he would excuse me I would speak to the secretary so that a list could be ready for him when he left.

When I returned he was still fumbling nervously with his hat and said there was one more thing he wanted to ask me about. His wife had said to be sure to find out about clinics but he would rather pay a doctor than go to a welfare clinic. I asked him what clinic he had in mind. Mrs. S had told his wife about a clinic at — hospital for kids with rheumatic fever. She had taken her own boy there twenty-five years ago and they had cured him. Mrs. B had wanted to take Herbie there but Mr. B had thought it better to have his own doctor and didn't want any welfare medicine. "Don't you think I am right, Nurse?" I said perhaps he would like more information about OPD. The setup of the clinic and the financial arrangements were explained showing that he would be paying for service and that free service was available only to those unable to pay fees; the necessity for making an appointment; the amount of time the clinic visit probably would take and the necessity for a letter of referral from his former physician. I asked if his family physician had mentioned the possibility of such care for Herbert. Mr. B hesitated and then said he had, but Mr. B had always paid for everything he got and did not want to start taking charity now. He had just given some money in a drive to help the poor and they needed such help more than he did.

I asked if he had discussed with Herbie the possibility of going to a

clinic. He said his wife had and Herbie seemed to be willing. "He had such a good time in the hospital in ——. The nurses made a lot of him. He's a cute tyke." He smiled and seemed animated when he talked about the boy.

I suggested he might like to talk again with his wife on the basis of the information he now had. I also asked if his wife had anyone with whom to leave the other children if she took Herbie to clinic. He said Mrs. S was a good neighbor and already had told his wife she would be glad to do this, and that his wife knew where the hospital was because she had visited a friend there. It was suggested that he should secure a letter of referral from his physician for use whatever his decision. He said he had not yet decided and I said he would want to think things over further. I said I knew he wanted to provide the best care for the boy.

I said I would like to see Herbie and Mrs. B. Mr. B said he would be glad to have me call at his home and tell Mrs. B the same things I had told him. "She doesn't feel the same way about charity that I do."

On leaving he seemed more relaxed and smiled. He thanked me and said he understood some things better. I gave him the list of private physicians and an appointment was made for me to come to the home the following Tuesday.

In the above interview, it seems clear that the nurse's approach was focused on Mr. B's behavior and what he said. In her thinking as she listened, observed, and responded, the nurse realized that the immediate problem was to get Herbert under the best and most appropriate medical care. The underlying difficulty, however, was Mr. B's aversion to what he considered "charity," which the nurse's experience told her was more marked than in most patients. Was this only because Mr. B came from a locality where community patterns demanded the maximum in independence and where community-supported projects were less well known, or was his feeling based on a special personal experience? The father's over-reaction was clear. The nurse could have said, "I think you get quite upset upon the idea of 'charity' and perhaps see this in a situation when it is not really there." In her judgment it was too soon to say this, and instead she made an appointment for a continuing contact. She herself felt strongly that the clinic, long recognized by private physicians as holding leadership in the care of children with rheumatic fever or its residuals, would offer the best plan for medical care. But, again, she did not say so. Instead, she gave clear information about clinic policies including those which related to fees. She had no doubt of the father's interest in the welfare of his child, even

though he was floundering in his decision as to what sort of care would be best, and gave him ready assurance that she was aware of his interest. That the "welfare" aspects of clinic attendance were the man's problem was brought out by his comments on his wife's acceptance of clinic attendance. The nurse had in mind that this problem could be worked through in the family and that her further contact could lead to help for the new baby, too, if this was wanted and desirable.

Subsequent notes show that after two visits from the nurse, the parents decided on clinic care for Herbert. After this decision was made, Mr. B told the nurse that when he was ten his family had been "on relief" for a winter. His whole family had been ashamed of this even though it was caused by his father's sudden serious illness. From Mr. B's description the family had been "branded" and were a source of gossip to the town for a long time.

### RECORDING

It seems appropriate to conclude this section on methods and skills with a discussion of recording. The following material is offered with some hesitancy because it may not represent in every respect a point of view generally accepted by nurses and nursing organizations.

There are some points about recording, however, on which most of us would agree. We realize that recording is a skill and also that it is more than a skill in that it requires a very thorough understanding of all aspects of nursing procedure and practice. For instance, no staff council and supervisory group can work out the headings for an infant and child's developmental history, or make good use of a record supplied with such headings, without a very careful knowledge of child development. When a staff undertakes record revision, it is interesting to find that this project necessitates the use of just about all that the staff knows about nursing.

The records of the nurse are used as the basis for continuing work in a situation, for agency statistics and trends, and to a considerable extent for supervision of the nurse. No one consciously denies their importance in so many words. Yet, during

a period of more than twenty years, it has never been, this writer's experience to hear a nurse say that she was happy about her own records or satisfied that they gave a true and accurate picture of her work; or that she entirely approved the method of recording recommended by the agency or felt she was given enough time to write up her material. This seems to be just as true for nurses who like records as for the many who do not. Sometimes nurses who like records and see their possibilities are even more dissatisfied than those who dislike them.

A typical picture of the district office of an urban agency is easily brought to the minds of many of us. The nurses are trying to "get out into the field." They are working at their date files, accepting assignments, having brief conferences and telephone conversations, taking additional time as necessary for staff conferences and, in the midst of everything, writing on their records with pen and ink, except for certain reports from other agencies and institutions which in some instances are typed on the records by stenographers. Even though these nurses probably are free to come into the office for a few consecutive hours of record writing, this is still done in pen and ink, with whatever degree of legibility, neatness, and speed the individual nurse is capable of. Some of these records are very complicated, including such items as visits allowed and paid for by insurance companies. The records are supposed to show all that the nurse considers important about a family in general and to give adequately detailed information about individual patients and her visits to them. It does not seem strange under these circumstances that there is a common saying among ourselves and among members of other professional groups that "The nurse knows more than she puts on her record."

The writer cannot help wondering what the administrator of a large nursing agency would do if, without secretary or dictating machine, she were required to create a permanent record of her daily work in pen and ink! As far as this writer knows, no other professional group is expected to record in this way. In other agencies or offices, shortages of secretarial help may occur and cylinders may pile up untranscribed, or a worker may have to keep rough notes in her record until she can get secretarial help, but it would be considered a wasteful use of the time both of

the worker and of those who must read them if her records were handwritten. Perhaps there are a number of nursing agencies in the country which have adopted what would seem to be a better method of recording, but only a few come to mind at this writing, and those are able to limit the case load more than most agencies can.

Nursing records which report bedside care, including medications and procedures, must be kept up to date in case of emergency and for quick reference at all times, and no doubt the exigencies of bedside nursing started us on the kind of quick daily recording which is our practice and for which we have continued need.

It seems to be true that some of our recording can, and probably should, be done in the home. Some identifying and factual data must be written down at the time it is given to us because it would be impossible to remember it accurately. But narrative records present a special problem. So many experienced and skillful nurses have reported discomfort on their part and on the part of the patient when they try to write such records in the home that it seems this plan should be reconsidered by those who continue to be in favor of it. Letting the patient "share" with the nurse what is put on the record can be thought of as an honest attempt to bring patient and nurse closer together. On the other hand, if the nurse observes behavior in the home which means something different to her from what it means to the patient — as often must and should be the case — and if it is not the appropriate moment to interpret what she sees to the patient, then the record written in the home is of little use to the nurse and must be supplemented when she returns to the office. This writer feels that the attempt to write the permanent narrative record, or anything except factual data, in the home is artificial and hinders rather than helps the relationship between nurse and family.

It seems inevitable that as public health nurses continue to acquire a better knowledge of human behavior and to apply what they know to their daily work, they will recognize an increasing number of important aspects of a situation and will consequently need more time for recording, more record space on which to record, and more help in the manual labor of setting

the material down. Otherwise it will be increasingly true of us that we "know more than we record."

This need for additional time and better record forms is not a sudden thing — the "fault" of mental bygiene. We have never had sufficient time for record writing. Any addition to the daily routine has meant taking time from something else. If we have an especially difficult case, we often must make special arrangements to record it; if we expect to do a time-study, we must make a special plan to give us time to study our time! In other words, our present methods of work, carrying with them the need for more thought and for better organization of our material, may well be the famous last straw that will necessitate difficult and far-reaching reorganization. It seems possible and even probable that, as nurses continue to learn to focus their thinking and methods, some patients will be helped more quickly. The time thus saved might be given to record writing, but in all probability it must be given to another patient. Employing more staff, both nurses and secretaries, seems to be the only logical development. And one realizes what this involves.

One hopes — at least this writer hopes — that in the fairly near future it will be possible for many nurses to have a "dictation day," or the necessary half-days, when they may retire to a dictating cubicle and record their material on cylinders. A good many nurses now practicing never will want to do this, for old habits will be too strong to change, in spite of dissatisfaction with present methods and results. But some nurses may be willing to try a dictaphone, and some agencies may be willing to attempt the complicated rearrangements this would involve and to work out better ways of making records available and a form appropriate to typed material. If so, we should have some useful pilot studies. It is also possible that some of the compromises used by groups which are hard pressed for dictating arrangements could be of interim help to us. Among these is the pencilled rough draft to be typed later.

We have thinking to do about the organization of the material, that we record. This applies especially to the narrative record and social data sheet. One of the reasons for the dislike of record writing that many of us feel may be the fact that a logical plan for writing these two records has not been developed.

Usually the nurse "keynotes" the visit in her first sentence and then goes on to state details. If she feels that a certain visit has been an important one she may record it at length, but the account may be rambling as she attempts to "get it all in." If, however, we agree that "what happened next"—in other words, the process—is the basis for understanding a visit or an interview, then it is also the basis for recording it. It would consume too much time and paper to try to record in full for each visit all that went on between nurse and patient in the order in which it occurred. But if one trains oneself to think in terms of the "process," one has a basis for summarizing the material logically. ("First we talked about . . . This led to . . . Then the mother seemed to feel that . . . So we agreed that . . .")

Now and again in the course of the contact the nurse will consider that a visit has been a crucial one and will want to record it almost verbatim as well as in careful sequence.

Whether or not the nurse should state her "impression" of the patient and the situation at the close of her record of a visit, or of a series of visits, is a question often discussed. Many nurses seem to be doing this and finding it a helpful and even an essential part of their record. ("I think Mrs. X can learn to take better care of her baby because . . .") Disapproval of the procedure has been expressed on several occasions in group conferences. Some nurses are reluctant to add such a notation, either because it labels the patient and phrases like "I think" do not belong on a nursing record, or because it is not "fair" to the patient to make an explicit statement in writing. The first objection seems to stem from the old-time hospital tradition of recording. The second is perhaps somewhat less clear. We all respect the wish to safeguard the patient, but underlying this wish there may be an insecurity on the part of the nurse that does not permit her to trust her own judgment. Perhaps she is not ready to accept behavior or standards different from her own, so that to record a departure from such standards means to her a criticism of the patient rather than a clear evaluation of the situation at the time.

A part of the record that has been found increasingly useful in recent years is the summary of the situation that appears at regular intervals or when otherwise indicated.



As we say, it is "good mental hygiene" to face the difficult problem of the content, organization, and means for recording, to attempt to discover why we lag behind in this respect, and to decide whether we cannot make some immediate progress in carrying out this part of our work on a more satisfying and more professional basis.

A nurse who was doing very good work was described as "both sensible and sensitive." By "sensitive" we mean perceptive. The meaning of "sensible" has been more confusing. To a number of us it has implied "common sense" — an intuition that enabled the nurse to work fairly well without reliance on disciplined thought. We may have accepted the common-sense approach as the practical approach. Yet, if we consider that "common sense" is actually only the point of view that is held in common by a group or a community and that is therefore sometimes prejudiced, shortsighted, or uninformed, we realize that we cannot rely on it as the basis for our work. We have more leadership responsibility than that. When we are reliably "sensible" we are doing effective work because we have a better idea of what we are doing and why we are doing it in just that way.

### »» PART III ««

## *Working with Groups*

In the preceding pages the relationship between the nurse and the individual patient has been the focus of discussion. The nurse also has a relationship with groups as teacher, speaker, or group leader, and with many professional and other groups as a member. As part of her professional activity she may lead classes in home nursing and first aid, "mothers' clubs" and, more recently, "fathers' clubs," sometimes groups of parents who wish to discuss child training methods, and a few play groups of preschool children. In addition the nurse is called upon to talk to parent-teacher associations, church groups, boards of selectmen or town councils, and other groups. People whom the nurse

sees successively as in a clinic or at a child health conference may also be considered to belong to a group because they are all using health services, and so have many experiences in common. The nurse may herself belong to a class or institute or workshop, or to a group organized for staff education, and she takes part in staff councils, supervisors' meetings, committee and board meetings, and case conferences within the organization. She also participates in conferences with other agencies.

Probably the majority of public health nurses would agree that we must think through relationships or procedures with groups as we have attempted to do with individuals. We need to know more about group development in the specialized meaning that the words are beginning to have. Since we are faced with the necessity of working with groups, we must be able to use group methods as constructively as possible.

At first the groups we worked with were mainly classes in which we taught certain definite material. We had to rely on the educational methods we knew—those by which we ourselves had been taught in school. These sometimes rigid ways of teaching were not always successful when we were the pupils; in turn they have not always been successful with the groups we have attempted to teach. Also it has not always been clear that a complex of "learnings" rather than a single expected "learning" takes place in the individual or group. The student never learns only what the teacher thinks he is teaching. One nurse describes her experience in an English course in first-year high school. The teacher realized that the class was not sure of its rules of grammar. Therefore, entire pages of Scott's *Ivanhoe* were diagrammed by the class. The sentences were long and involved and a source of misery to most of the pupils. The nurse learned a great deal about dependent clauses and the like, but she also learned to dislike Scott's novels without ever having read them as novels, and furthermore to dislike any book that looked "long." The result was that this nurse shied away from concentrated reading until she was able to outgrow these destructive indirect learnings.

With the shift from teaching facts to teaching people pretty well established, a shift in methods of teaching in class and

group work has followed, or is taking place. Some of our methods seem to be in this transition stage at present.

Meetings that we organize for ourselves in order to learn new material or to clarify problems are an example of the change that has taken place. In the past we usually arranged a lecture or a series of lectures on any subject we were interested in, with whatever follow-up and application could be managed within the organization. We still see a place for the lecture. However, now we are asking for it when the subject on which we need help is almost entirely new to us or, on the other hand, when we are well informed on the subject in general and want amplification of a certain aspect of it. In using the lecture method, we are highly selective in our choice of subject matter and lecturer. The lecturer tries, with the help of those who invite him, to familiarize himself with the group's background and situation, is aware of the need to plan follow-up and application, and sometimes even assists in providing such opportunities. If his schedule will not permit him to participate to this extent, he often does not accept the invitation to speak.

The method of group education in greatest contrast to the lecture is the workshop or work conference designed to bring together, in a learning situation that will promote free discussion, nurses who have a fairly homogeneous background and who share common problems. Resource people are available if the group wishes their help.

Our institutes represent an intermediary step between the other two methods in that they combine lecture and group discussion. Unlike the workshop, the institute is planned specifically in some detail and is conducted by a directing group. It seems probable that the institute is a good medium at present for filling in the gaps in our knowledge of mental hygiene throughout the country.

As we become aware through our own experience that learning can be realistic and satisfying when teaching methods are used that are appropriate to the material to be learned, and as we realize how much we can learn from one another in group discussions we are able to put these same values into our work with groups of patients.

Among the latter are play groups for preschool children

which nurses have organized or with which they assist. Usually the group meets in a part of the reception room, or in an adjoining room, during a child health conference. Child-size tables and chairs and simple play materials are supplied. The purpose of the group is to interest the children and observe them while their mothers are talking with nurse or doctor and to show the mothers some of the toys and equipment that children enjoy. Another type of preschool play group has a similar but more ambitious purpose. Dr. Margaret Fries of the Pediatric Clinic, New York Infirmary for Women and Children, where such a group was conducted, summarizes its objectives as follows:

Specific benefits of such a play group can be: To furnish an added incentive for both children and parents to return to the hospital for follow-up work or treatment; to furnish a direct means for learning about, but not the etiology of, the child's adjustments. . . ; to gain insight into the validity of the mother's reports and to furnish a check on the case-worker's observations; to give an indirect insight into family relationships; to point to the steps necessary in future therapy; to obtain, through group activity, some therapeutic results.<sup>42</sup>

Not all children profit easily or at once from such groups. For example, at a meeting of the American Orthopsychiatric Association, which conducted a session on play groups, Dr. Oscar B. Markey suggested that among very young children only those who had worked through to a fairly good relationship with their own parents could hope to profit from a group of this kind, the main purpose of which is not intensive therapy. A child in such a group usually turns to the adult leader for help in finding his feet in this new situation before approaching the other children. If he has not found security in the relationship with his own parents, especially his mother, he may not readily turn to the group leader. Yet such children are often the very ones who need this kind of group and its adult leader *very much*.

One can see that a preschool play group which has a considerable therapeutic purpose is not to be undertaken lightly and requires trained personnel. But its experience and the methods it has developed may offer valuable suggestions to nurses who take part in the less intensive type of play group that is an adjunct to child health conferences or clinics. For instance, the playroom in a prophylaxis clinic at The New York Hospital helps to make

immunization a less frightening experience to its patients. Children are taken to the playroom immediately after inoculation and helped to play there until the passing pain of the treatment has been erased by pleasure over toys and playmates. As a result, they seem to be less afraid of the next clinic visit and of doctors and nurses wherever they meet them.

For a number of years the Boston Dispensary has planned activities for children who are waiting to see clinic physicians or who have accompanied parents to the dispensary. Skilled teachers, employed to lead the group, maintain the interest of the children at a high level, with the result that the visit to the clinic is no longer associated just with tedious periods of waiting or with fear or pain, but is also remembered as a pleasant experience. When the examining physician is ready to see his patient, he is quite likely to come to the alcove adjoining the waiting room where the class is being conducted and seek out the child himself. A visitor who observed this remarked that contact with this group-work project seemed to have a salutary effect upon the staff also, that she had never seen busy clinic physicians and nurses approach children more pleasantly. This project is now under the supervision of a nutritionist, is known as the Nutrition Education Department, and is one of the services of the Frances Stern Food Clinic. Parents, too, become drawn into this group or listen from the sidelines and some of the material is designed to be helpful to them as well as to the *children*.

Classes in first aid and in home care of the sick are another form of group that the public health nurse teaches. As a rule these are highly successful and bring the satisfaction of skills well learned both to the members of the class and to the nurse. One can see why these groups present fewer difficulties than any others we are called upon to lead. The material lends itself to demonstration and to practice on the part of the members of the class. Furthermore, it is simple and concrete so that each member can be relatively successful in understanding and using it. Perhaps a more important reason for their success is that first-aid material and suggestions for simple bedside care are interesting without, as a rule, being charged with emotion. We as nurses are at ease with this material ourselves.

In contrast to these classes, which are definitely within our province and which we handle easily, are groups of parents who wish to understand more about child training. Nurses are not alone in finding parent groups difficult. Here there is no universally accepted body of information to use as a basis of discussion, nor could any subject be more loaded with emotional content for parents than ways of bringing up children. The more objective the parent may insist he is, the more difficult such group discussion may be for him. We realize how easily it can disintegrate into heated statements of personal beliefs and methods or into insistence on the discussion of individual problems to the exclusion of those of interest to the group as a whole. Definitely stated opinions as to "good" methods for use with children create misery in certain members of the group who feel they cannot measure up to the standard of child care set for them. A number of nurses who have attempted to lead a group of this kind have discontinued the experiment after being convinced that without a trained leader the dangers outweigh the advantages. However, it has been shown that many parents do find some release from anxiety as they discover, through discussion groups, that other parents have similar problems, and gain new perspective toward themselves in relation to their children. Under various auspices, careful group work with parents is being carried on with continuous study of the methods and personnel required. For example, the Institute of Child Welfare of the University of Minnesota aids parent groups throughout the state, helping to organize and conduct study groups and to train leaders.

Since nurses admittedly are often not trained group leaders, it would be simple merely to decide that parent groups present problems too complex for us to handle, at least until we are better equipped, and to refuse to have anything to do with them. This easy way out is denied us, however, for the demand for such study groups persists, often in communities in which the nurse cannot enlist skilled help. Various public health nursing organizations receive requests for a sort of graduate course from former members of mothers' clubs after the arrival of their babies. To say to these mothers that the matter is all so difficult that it had best be left alone would not be very helpful. Failure to provide some form of study group in child training to meet

the continued need may seem particularly unfortunate when one realizes how long it takes to develop new attitudes and how little can be assimilated in the eight or nine group meetings mothers have attended as antepartum patients. Before they can really change and grow as they may wish to do, mothers may need and want several additional series of meetings where they may discuss child care and family relationships as special problems actually present themselves.

Perhaps we can find ways to avoid some of the difficulties that arise in parent groups when we are the logical persons in a community to assume the responsibility. We can, for instance, help the group itself to develop skill in group discussion; we can present, when the occasion arises, such knowledge as we have, unafraid of loss of prestige if we do not always have full information or the "final answer"; and we can help to make appropriate resource people available as we find them. One or another professional or lay group may lead the way in establishing study groups for parents in any community, but it begins to be clear that this activity will be a continuing responsibility, and that the auspices and the planning will vary with the community.

School nurses may have had more opportunity than other public health nurses to observe changes in work with groups and to make use of new methods. The day is not long past when, in carrying out school health work, school teachers and nurses alike regarded the class primarily as a convenient and efficient unit for health inspection. The dangers of this superimposed, regimented concept of health education are now seen to outweigh its conveniences. Increasingly, classroom discussion has become a medium for learning not only health facts but also the attitudes toward health and toward disease prevention that take the place of fear and prejudice when put in the context of the child's interests.

### MOTHERS' CLUBS

Of all the groups with which public health nurses work, classes for antepartum patients — "mothers' clubs" — are the best established and the most numerous. Because of their number and the variety of methods used, they give a panoramic view of our

group work, and much of the remainder of this section is devoted to the discussion of them.

Public health nursing organizations in certain areas are giving much consideration to the purpose, methods, and results of this activity. Evaluation of results in terms of what mothers learn varies. Nurses in some organizations are frankly disappointed that so little of what the mother has been taught in the antepartum classes is carried over into her care of the newborn baby. A nurse going into the home after the baby's birth may find that the mother has forgotten procedures demonstrated in the classes. No study has yet been made to show how far the mother's ability to use what she has been taught correlates with the opportunity given her during the antepartum classes to practice the techniques and skills the nurse describes.

Nurses in other organizations do not expect the mother to be able to carry out in much detail in her home what has been taught in the group. They are satisfied if they find that a mother seems readier for help with the baby apparently because she was a member of a group of antepartum patients and therefore learns more quickly. These nurses feel that eight or nine meetings is too short a time for a mother to become skilled in a variety of new procedures. They suggest, too, that added fear and insecurity inevitably enter the situation when "your own baby is here" unless the mother has had much opportunity for close contact with her baby in the hospital, perhaps by means of the "rooming-in" plan. A father once rushed wildly into the office of the former East Harlem Nursing and Health Service, saying, "Come quick. My wife has three diplomas but she doesn't know what to do with the baby."

A mothers' or parents' club can, if this is desirable, be a quite ambitious undertaking. It can make use of leading medical, nursing, and other specialists in the community as a whole. Both informative sessions and group discussion can be arranged. The former include talks and demonstrations by specialists, and visual aids. Such a series of group meetings was carried out co-operatively by a city-county health department, the local community nursing service, and local obstetricians, psychiatrists, pediatricians, social workers, and nurses, and is reported by Dr. Lloyd J. Thompson and others.<sup>8, 101, 106</sup>



Comments by mothers showed that they learned useful facts and that anxiety diminished as they gained confidence in their ability to take care of the baby. Furthermore, they thoroughly enjoyed the meetings. Some group workers think that there is no reason for gathering together a group of women just because they are all pregnant. They suggest that one might rather consider pregnancy in a fairly well-adjusted person as one of many interests, such as church or civic affairs or handicrafts, any of which might offer a more reliable common interest. There are nurses who agree with this point of view. They feel that we sometimes idealize, or at least overemphasize, the condition of pregnancy by making it the reason for forming a group, and that work with the patient should be carried out by the nurse individually in the course of customary family health work.

On the other hand, group leaders who have worked with mothers' clubs or have observed many of them recognize that the groups have something of value to offer their members in addition to the instruction for the expectant mother and the opportunity for sociability that they provide. This "something" may be a renewal of self-esteem, lost perhaps because the patient feels caught in a round of household cares, now made more difficult by her pregnancy, so that she seems just a necessary but unconsidered cog in the family wheel. When she comes to mothers' club it is obvious to her that the leader, and the organization which the leader represents, thinks pregnancy interesting and important. This attitude of acceptance and interest tends to be communicated to the group as a whole so that all the members share it. In turn it affects the individual member, building up her realization that her pregnancy and she herself are of consequence, and so perhaps increasing her acceptance of the pregnancy. Numbers of nursing records state that an antepartum patient told the nurse she felt better about her pregnancy after joining a group of this kind.

Even in prenatal clinic — a much more loosely organized group than the mothers' club — this feeling of unity can be sensed by patients on the basis of their common experience of pregnancy. In the report of a study of anxiety in pregnancy and childbirth, the statement is made that:

On the whole, there is a feeling of unity in the prenatal clinic not usually seen in general medical clinics. . . . The women studied identified with one another and associated the anticipated childbirth with the clinic set-up. . . . Sharing a common experience was described by the women as valuable in making the experience less strange and difficult.<sup>47a</sup>

The purpose of group work with pregnant women always has been, and still is, education. But the mothers' club, like all groups, has a broader educational purpose as well, in the sense that any process that broadens and deepens experience is educational. This would sum up the whole purpose of many groups whose leaders feel that any more defined purpose would be narrowing. In such groups the entire choice of material studied would depend on the wishes of the group and the material itself would be important only as it contributed to the individual's development through group contact. However, public health nurses are convinced that we have information about pregnancy that will help a woman while she is expecting her baby and after it is born and, as health workers, we wish to place this information before groups of pregnant women. At the present time we say that much of this must be presented within the limits of a small number of group meetings. This time limit is set to some extent by the pregnancy itself.

Ways of teaching antepartum classes are undergoing increasing scrutiny as nurses become aware of the emotional implications of both the subject and the methods used. We realize that an apparently simple health "fact" may carry so much emotional difficulty to certain mothers in the group that what they actually learn is very different from what the nurse believes she has taught. As a matter of fact, our mothers' clubs offer to the leader many of the same problems as parent study groups, since it is the rare woman who has not some emotional difficulty about one phase or another of her pregnancy and home situation.

The statement that the newborn baby should have a quiet, reasonably ordered home is a simple health fact, yet it has emotional implications for many mothers. No one denies that the newborn baby needs this kind of environment. But one can picture what is arising before the mind's eye of some members of the group if the nurse makes this statement. Crowded rooms,

large families including other children and grandparents, street sounds, and the noisy spill-over from the lives of neighbors cross the consciousness of many listeners who are city dwellers. How can a woman living in such a home give the newborn baby peace and quiet, and must the baby suffer from a bad start in life because the mother cannot give him what he "should" have? More than this, in rural and urban areas, and to those who are financially comfortable as well as to the poor, may come the unhappy realization that peace does not exist between the parents even if quiet and order prevail in the housekeeping. Again the thought passes like a cloud across the mother's mind that she is giving her baby a bad start in life and that things in general are pretty hopeless. Some of us who have offered to a group of women a rather smug description of the kind of home the newborn baby needs have seen the faces of some of the listeners go blank and inscrutable and thereafter have found other ways of making the point or have tried to bring out through group discussion that peace and quiet are only relative. Otherwise, these mothers may have been taught that they have not the proper home to which to bring a newborn baby instead of learning that the infant needs protection against confusion and tension.

The desirability of nursing the baby and of preparing for this during pregnancy may be another danger point. While some physicians are less insistent that the mother should attempt breast feeding, many others continue to feel that breast feeding is preferable. Sometimes we as nurses tend automatically and didactically to stress its advantages. However, a mother in the class may know that she cannot plan to nurse her baby. When the nurse states unequivocally the advantages of breast feeding to such a mother, who may already feel that a "good" mother will try to nurse her baby, one can see that the mother will grow apart from the group. What the mother really learns in this situation is that well-informed people seem to think breast feeding is essential, that she cannot do this herself, and that therefore, evidently, she must get along as best she can without "scientific" help. In other words, she is learning to do without the nurse and perhaps even without the doctor.

On the other hand, even some of these patients can remain well within the group if the nurse has helped the members to

express themselves about breast feeding. Enough of the group always seem to do this, and such a variety of opinion and experience is presented that no member need feel she is an outcast. The nurse has the responsibility of summarizing, and can say what she thinks, too. A diversity of opinion on this subject lends strength to what the nurse can say about the importance of the way any kind of feeding is given in relation to the growing security of the baby. If the nurse sees evidence of such marked rejection of pregnancy on the part of any in the group that this material, carefully offered, makes trouble, she will feel that such members need special help, whether or not it is available. While any group is therapeutic in that the members, including the leader, help one another, the purpose of a mothers' group is not intensive therapy directed toward difficult, well-established emotional problems.

Again, many nurses believe that pregnancy is a universally desirable and even a blessed condition, and that every mother can accept it as such if she is encouraged to have an appropriate attitude. In trying to impose this belief on their patients, these nurses may be maintaining understandable loyalty to their convictions, but they may find that they are alienating patients instead of convincing them if they dwell on the beauties of motherhood before a group of women of whom a number may be finding their pregnancies unwelcome.

In other words, in examining the content we wish to make available to mothers' clubs, as well as in planning the way in which this material shall be presented, back we come again, as in working with the individual patient, to the attitudes and standards of the nurse on which depend the success of the relationship between her and her patients. It is possible for the leader's attitude to add to the self-esteem of the members of the group; it is also possible for the leader to be blind to the implications of material which she may offer didactically, and in this way increase the discouragement and the resistance to prenatal care that some of the group members already feel. Not only the standards of the individual nurse but also some of the more stereotyped standards of the profession may be responsible for an attitude on the part of the nurse that has such an effect on the patient.

Time was when we thought every staff nurse in turn should

have the experience of leading a group — usually a group of expectant mothers. If the nurse's characteristics were such that she could lead a group only with difficulty, we hoped that the experience would "develop her personality" and add to her self-confidence. One organization after another has abandoned the selection of leaders by rotation or because a certain nurse needed "hiring out." The fact is increasingly accepted that each nurse makes her special contribution in her own way, whether by her skill in individual contacts or by her gift for working with groups. We do not wish to minimize the advantages that training and experience in group work bring every nurse; but we would emphasize here the lack of economy and the near cruelty that results when the discipline is imposed on those who are not fitted for it. All of us must be able to meet groups occasionally in the course of our work. However, it is generally recognized in nursing organizations that their mothers' clubs profit from leadership by nurses who are especially gifted in this respect.

On the other hand, a nurse's difficulty in leading a group may be due to sheer inexperience and to need for help in the preparation of her material and in the method of presenting it. Like the inexperienced public health nurse who is planning a home visit, the nurse who is about to lead a mothers' club for the first time may spend anxious hours preparing, point by point, the material she considers essential and then spend additional hours memorizing it. Sometimes she feels, or is made to feel, that she has been a failure if she omits any of these points from her talk.

However, as her familiarity with the subject grows, the nurse becomes freer to roam over it as the group may desire and to enlarge upon certain aspects that seem to interest them and to need development, and to draw upon her own store of experience for illustration and application. Her manner becomes less formal and she is able to show the tolerance and friendliness which she really feels and which help to relieve the tension of the group. Her sense of security as a group leader develops. As she works with one group after another, she realizes that a certain amount of unease and stiffness is inevitable at the first meeting of any new group, or perhaps even at the first several meetings. She expects this as "normal." Later she and the members of the group recognize with pleasure that they begin to

"feel like a group" and that verbal expression and give-and-take are increasingly easy.

Useful discussion, one can see, will take place only on the level of experience of the majority of the group, for it is only on this level that they can find new material applicable. Some groups will progress toward broader ideas and toward new concepts more slowly than others. If discussion is burdened by prejudices or superstitions, progress must be slow if it is to be sound, even at the risk of taking valuable time from the next topic in the series.

A difference may exist between lively group discussion and helpful group discussion. The illustration that comes at once to mind centers about the widespread superstitious fear of marking the baby in utero, a topic which rarely fails to bring out active participation by the group. Sometimes the nurse rejoices in the interest roused by the subject but does not use it constructively. She may set the tone of the discussion by commenting with a tolerant smile on the fact that certain "old-fashioned superstitions" exist concerning birthmarks. While members of the group may then contribute appropriate individual experiences, they will do so with an effort at similar tolerant humor and so merely repress their fear without getting the relief of expressing it and defending it. The same thing will happen if the leader cuts short the discussion, since the true attitudes of the group usually come but slowly to expression. Opportunity for reminiscence, for the expression of differing points of view, for gradual arrival at the point where the group knows how they really do feel about the superstition of marking the baby, may bring feelings into the open with some release of fear so that the leader finally finds an opportunity to explain some of the facts of anatomy and physiology that bear on the question. This slow process also helps to establish a working relationship between group and leader since the nurse's amusement over this superstition or her premature denial of it as contrary to fact may well lead to a real, if hidden, resentment on the part of the group. The factual explanation which the leader can at last safely place before the group and her final summary further exemplify the leader's function. The group's discussion, while it was necessary, was perhaps founded on opinion only and would have been superficial and

ineffective without the leader's presentation of the facts at her disposal.

Group discussion is one form of interaction among members of the group. Teaching by individual members of the group may be another. Some of the women present are not only articulate but good teachers as well and will enjoy recognition of their ability. They have had experience with medical supervision, with antepartum care given by the agency, with the helpfulness of early planning, which they can pass on to other members of the group more directly than the leader advisedly may do.

A woman attending a mothers' club during her second pregnancy told the group — with recourse to Italian phrases when her broken English failed — that she had doubted the value of antepartum care during her previous pregnancy. Her mother, who lived with her, also thought care unnecessary since the pregnancy had seemed to her normal. Swelling feet and gradually increasing dizziness were merely discomforts to be endured. But the nurse had "hothered" her until she had visited a physician and later joined a mothers' club. She was glad she had done so since she was very near to a bad sickness and perhaps to losing her first son. This mother concluded her story by saying, "Now I give the cod-liver oil and all," and for confirmation nudged an older companion — the grandmother — who nodded vigorously.

Such direct teaching by members of the group is invaluable just because it is done *in the group*, in the presence of the leader. All of us are familiar with groups whose most heated and telling discussion takes place after the meeting is adjourned. When this happens, it may be because the members were dissatisfied with something that was said in the meeting, or because they were not given an opportunity to express themselves freely, or because they still were not able to make full use of the opportunity to express themselves.

Opportunity for some kind of handwork is provided by many organizations. Such work may be what is known as "pre-activity," which means that materials are supplied on which the mothers work before the day's subject is taken up for discussion. Conversation between rather shy mothers is made easier in this way and new members appear to be more easily assimilated. A mother coming to one such group for the first time said she was not

interested in sewing. Later the leader glanced her way to find her hard at work on a baby jacket. She smiled when she caught the leader's eye and remarked that everyone seemed to be enjoying herself so much that she had decided to get to work, too. Organizations that conduct mothers' clubs have differing points of view about the value of encouraging such handwork before and even during the group meeting. Some feel that it is valuable because it provides a layette and creates ease among the group members. Others feel that it is expensive and an added burden to the nurse. Sometimes it is true that the handwork is uninteresting or the patterns out of date. Sometimes, perhaps, the leader herself is not interested and so has unconsciously minimized the value of the project or failed to make it seem valuable to the group. When she is assisted by a volunteer, as in a sewing project, the nurse, of course, is responsible for carrying her aide along with her in the study and understanding of group work.

Whether or not refreshments should be served at these group meetings is a much debated question. Because of the physical effort they have made in coming to the place of meeting, an organization may feel it is desirable for the women to have something to eat. Also, an opportunity is provided in this way to demonstrate good foods. Nurses are sometimes reluctant to have the women make the occasion a kind of group activity by providing and serving the food themselves because they feel the refreshments and the serving of them should be a gift from the nursing organization. Their discomfort may be based partly on the realization that some of the women are financially unable to provide even the simplest type of refreshments. Sometimes, however, one realizes that the desire of the nurse to act as hostess has blinded her to the satisfaction the mothers themselves may have in organizing and carrying out this part of the program.

The inability of some members of the group to participate because of shyness or language difficulty may be a problem. The leader watches for the smallest hint that such a patient has something she would like to say. Or she may use what she knows about the patient to draw her out, in order to increase her pleasure in the group. On the other hand, an overactive member



may also create difficulty — one of the most baffling situations the inexperienced leader faces. To wait until a reaction from the rest of the group stills this aggressive member may take too long and prove too disrupting. If the leader takes it upon herself to quiet an argumentative or excited individual she falls into the trap of old-time discipline — a situation which both the difficult member and the rest of the group may unconsciously enjoy and which may be repeated, or which may arouse hostility in the group. The suggestion has been made that such behavior is most satisfactorily met by talking outside the group meetings with the woman who shows special problems.

The nurse who knows individually the women in a mothers' club may have an advantage over the nurse who sees them only in the group. However, there is a danger that a patient who has thought of the nurse as "my nurse" may have a sense of loss when she sees that other women have a similar relationship with her. This is a perplexing dilemma because sometimes the patient's dependence on the nurse and the possessive feelings toward her that result are attitudes which may be helpful to the patient, at least temporarily.

A nurse who knows the members of the group well will know something of the cause of the difficulty that individuals within the group are experiencing and whether she can be of assistance herself as a group leader, or whether she should make other resources available. One sees that activity on the part of the group does not release the nurse from her responsibility as a leader. Though the group becomes increasingly self-reliant, it still needs the leader's stimulation, balance, and guidance. Her relation to the members of the group is not a casual one.

Analysis and understanding of what happens in groups and to groups have become subjects of research and experiment, the results of which are now beginning to be put into teachable form for those who wish such help. A commonly used name for this material and method is "group development." It is based on an understanding of "group dynamics," and thus we see the concept of dynamics becoming as essential in work with groups as a previous chapter indicated it to be in work with individuals. In our work with groups of patients we shall probably not make frequent use of the more formal methods, which are bringing

increasing success to what are called "action groups" whose object is to reach a definite consensus of opinion leading to action by the group. However, one mothers' club functioned as an action group when, after discussion involving the whole group, and several changes of plan by the group, it voted to continue as a parents' club, with parents entering or re-entering the club as a new baby was born. It is possible that board and committee meetings will make increasing use of formal group methods. *A Thousand Think Together*<sup>18</sup> is a report of three of our own meetings in which this method was successfully used.

We can all gain from the study of group dynamics a deeper understanding of group interaction. The nurse who has achieved some knowledge of and "feel" for the dynamics of the individual has a head start on this. That is, the nurse who knows that individuals have conflicts, of which they often are unconscious, and who knows that they try to solve or soften their conflicts by various defenses formerly known as "mental mechanisms" and now called "dynamisms," can carry over this knowledge into a better understanding of groups. Many would say that only workers who have some knowledge and understanding of the individual can expect to understand groups and work with them safely.

In our groups of patients we see individuals who show aggression, either as an established habit of reacting, or in response to the frustration of being contradicted by others in the group or of being denied by the group as much attention and admiration as they would like. Or we see the group member who denies what seems to others obvious fact and experience. Or we see the dependent individual. Or we see the very insecure person who either overcompensates by talking too much or is "pushed around" by others in the group. Some of this behavior is characteristic of all of us in a group situation and thus can be understood and accepted or allowed for, can ultimately be brought out more easily into the open, and so used constructively. If some members of the group become more able to do this, others will be more ready to express and describe their real feeling toward the subject under discussion and toward what others have said. When a group has this as an accepted purpose, the meeting or

series of meetings is different from the "gripe session" which most of us can call to mind.

In addition to understanding individual reactions, and the way in which they interweave and can help or hinder a group, one realizes that any group such as a mothers' class is a small replica of society. Probably it will have a "minority group" represented perhaps by only one person. The others may feel toward her the hostility that is based on unrealized fear because she is of "better" class or "lower" class, or because by birth or way of thinking she is a little-understood stranger. Those who represent the fortunate in-group do not need to question to any troubling extent the way they think and feel or their place in the group. In a mothers' class they may be women who have had other children, or women who knew the nurse prior to attending the class. An actual small image of larger social difficulty may be seen if the group contains representatives of different races or religions. In a mothers' class where the purpose is to help each member both by direct teaching from the leader and by free discussion among the members, such differences and the way in which they help or hinder progress may not be understood by the group nor does the nurse interpret them, as would be the case in an action group, but they are there for the nurse-leader to see. She must be observer as well as leader. She is aware of what is taking place and hopes, by trying to see that all points of view are recognized and by stressing similarities rather than differences, to help the group to work well together so that all the members "belong," are less frightened at new points of view, and so are able to learn.

We ourselves may have no direct responsibility for groups organized primarily for therapy but we often may be working with individual patients who are members of such groups or in a clinic which conducts them. In therapy groups the leader is usually a psychiatrist, and interaction among members who have somewhat similar problems is used as the basis of therapy for the individual members. This method was used with merchant seamen who had been torpedoed and who were more quickly able to relax when, with the help of the psychiatrist, they shared their

experiences and feelings with others in a group. We are also beginning to be familiar with the use of group therapy in hospitals for the mentally ill, especially with certain schizophrenic patients. Other examples which come readily to mind are: the group therapy sessions for patients with multiple sclerosis at the Veterans Administration Mental Hygiene Clinic in New York City; a discussion group for parents of diabetic children held over a year's period at The New York Hospital "with gratifying results both for the parents and the physicians in charge of the children";<sup>89</sup> a group of parents of seriously ill schizophrenic children at Bellevue Hospital, New York. No one who has ever been privileged to attend sessions of such groups as a visitor on a "good day" comes away without being impressed with the help that sick and troubled people can give one another.

#### GROUPS SERVED BY CLINICS

The many and various clinics that we help to conduct the country over bring us into a somewhat different kind of group situation. Most of the child health conferences and diagnostic and treatment clinics show us a group situation with which the individual already finds himself quite familiar as part of his daily life. The clinic is set up to serve him — the individual — and through him the community. But there are many individuals to be served, and the numbers of people using the service make up a sort of group that exerts pressure and influences the care and attention the individual receives. He meets this kind of pressure when he tries to ride a crowded bus, when he tries to get his child into college, when he tries to find a place to live, when he tries to sell his produce. On the one hand there is reassurance in this because the individual sees that others are "going his way." On the other hand he must often step aside and submit to rules and routines which the presence of the "group" makes necessary.

In the clinics and conferences where we have or share responsibility for planning and setup, our goal is to capitalize on the resources which the common need of a large group makes possible, and then to make these resources serve the individual smoothly and helpfully. This brings the administrator or planning group

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series of meetings is different from the "gripe session" which most of us can call to mind.

In addition to understanding individual reactions, and the way in which they interweave and can help or hinder a group, one realizes that any group such as a mothers' class is a small replica of society. Probably it will have a "minority group" represented perhaps by only one person. The others may feel toward her the hostility that is based on unrealized fear because she is of "better" class or "lower" class, or because by birth or way of thinking she is a little-understood stranger. Those who represent the fortunate in-group do not need to question to any troubling extent the way they think and feel or their place in the group. In a mothers' class they may be women who have had other children, or women who knew the nurse prior to attending the class. An actual small image of larger social difficulty may be seen if the group contains representatives of different races or religions. In a mothers' class where the purpose is to help each member both by direct teaching from the leader and by free discussion among the members, such differences and the way in which they help or hinder progress may not be understood by the group nor does the nurse interpret them, as would be the case in an action group, but they are there for the nurse-leader to see. She must be observer as well as leader. She is aware of what is taking place and hopes, by trying to see that all points of view are recognized and by stressing similarities rather than differences, to help the group to work well together so that all the members "belong," are less frightened at new points of view, and so are able to learn.

We ourselves may have no direct responsibility for groups organized primarily for therapy but we often may be working with individual patients who are members of such groups or in a clinic which conducts them. In therapy groups the leader is usually a psychiatrist, and interaction among members who have somewhat similar problems is used as the basis of therapy for the individual members. This method was used with merchant seamen who had been torpedoed and who were more quickly able to relax when, with the help of the psychiatrist, they shared their

experiences and feelings with others in a group. We are also beginning to be familiar with the use of group therapy in hospitals for the mentally ill, especially with certain schizophrenic patients. Other examples which come readily to mind are: the group therapy sessions for patients with multiple sclerosis at the Veterans Administration Mental Hygiene Clinic in New York City; a discussion group for parents of diabetic children held over a year's period at The New York Hospital "with gratifying results both for the parents and the physicians in charge of the children";<sup>22</sup> a group of parents of seriously ill schizophrenic children at Bellevue Hospital, New York. No one who has ever been privileged to attend sessions of such groups as a visitor on a "good day" comes away without being impressed with the help that sick and troubled people can give one another.

### GROUPS SERVED BY CLINICS

The many and various clinics that we help to conduct the country over bring us into a somewhat different kind of group situation. Most of the child health conferences and diagnostic and treatment clinics show us a group situation with which the individual already finds himself quite familiar as part of his daily life. The clinic is set up to serve him — the individual — and through him the community. But there are many individuals to be served, and the numbers of people using the service make up a sort of group that exerts pressure and influences the care and attention the individual receives. He meets this kind of pressure when he tries to ride a crowded bus, when he tries to get his child into college, when he tries to find a place to live, when he tries to sell his produce. On the one hand there is reassurance in this because the individual sees that others are "going his way." On the other hand he must often step aside and submit to rules and routines which the presence of the "group" makes necessary.

In the clinics and conferences where we have or share responsibility for planning and setup, our goal is to capitalize on the resources which the common need of a large group makes possible, and then to make these resources serve the individual smoothly and helpfully. This brings the administrator or planning group



to the fore, or the administrative function of the nurse who is "working alone." We see this administrative function broadly, realizing that clinic service is an area where cooperative planning between hospital nursing service and public health nursing service takes place in referral and follow-up of patients as well as in nursing service in the clinic itself.

There are grave administrative problems in clinics which it is hard to know how to meet in view of the difficulties which give rise to them, yet which stare us in the face as sources of destructive learning for staff and patient. For example, it was only six years ago that a report of public health nursing service in clinics included the following description:

The physical environment of clinics is frequently still of a kind to violate the human dignity of patient and worker. . . . The workers were so handicapped by location, space and arrangement of the clinic quarters that individual recognition or attention was almost impossible as the patients took their turn at treatment in depressed, sullen silence.<sup>12</sup>

Again, it is interesting that this same report suggested that "educational aspects of services are neglected or only incompletely developed in many clinics, *particularly where treatment predominates*, as in those for venereal disease and crippled children." As the administrator sees — if she can stand away from the pressure of the clinic — these treatment clinics can offer the readiest of all teaching opportunities if personnel can be given time to use them.

*It was stated in an earlier chapter that our clinic service offers one of the natural opportunities we have to encourage healthy attitudes in patients of all ages. And the administration of the clinic is the basis for this preventive aspect of our work. If the clinic is in a district within easy reach of the patient at hours when he can attend; if the clinic personnel is constant so that he gets to know the nurses and doctors he sees there; if he understands why he is referred from one clinic to another; if records are accessible, safeguarded, and written up in adequate detail; if the appointment system and the fee system are thoughtfully planned and applied; and if cooperation with other community agencies is established, the patient may be helped to meet a trying experience. Sometimes we are concerned because clinic rooms are shabby or inadequate. But, shabby or beautiful, these*

rooms and our arrangement of the furniture and equipment in them can show patients that the clinic staff practices what it teaches. One nurse tells of a startling disregard of this opportunity. She described an eye clinic which used a hallway as a waiting room. The space was sufficient and made reasonably comfortable. However, the staff seemed unperturbed by the fact that but one dim light had been provided by which patients could read the magazines placed on the table.

It is easy for us to understand that tired ambulatory patients, patients awaiting diagnosis, patients entering the environment of the clinic for the first time, patients who must return to clinic after a previous painful experience, are anxious people. We wish to provide clinic service that not only alleviates but prevents this anxiety as far as possible through its general policies and setup as well as through individual contact. Dr. Mabel Huschka and others responsible for the running of a pediatric prophylaxis clinic have published a report of the simple, scientifically valid procedures the clinic used that helped to reduce the anxiety of the many children who were treated there.<sup>53</sup>

Nurses who work in clinics, particularly in specialized clinics, see behavior on the part of some patients which is not primarily dependent on general clinic management, but which occurs in enough of the patients who visit the clinic to suggest that it may be characteristic of the "group" and may have a cause common to all the members. A nurse employed in a tumor clinic where a number of patients suffering from cancer of the throat or mouth were diagnosed and treated was much discouraged because these patients seemed slow to benefit from her teaching. The clinic ordered throat and mouth irrigation which the patient was to perform at home with equipment provided by the clinic. Not only were printed instructions given each patient, but the nurse talked with him following his appointment with the physician, demonstrated the use of the equipment, and explained the printed instructions. She said that patients often seemed apathetic about the procedure and frequently went away without the equipment. They told her they understood instructions but the next clinic visit proved they had not understood. In this instance, the staff decided that no matter how hard it tried to lessen a patient's anxiety, the clinic visit did not provide enough time

to teach new skills and routines to these deeply anxious patients. A cooperative arrangement was made by which the local agency for bedside nursing followed up all new "cases" in order to demonstrate treatment procedures and explain instructions. This showed good results in clinic attendance and in participation by the patient. It is interesting to remember in this connection how much independence and skill even patients heavily burdened with painful and difficult conditions can acquire as they become less afraid. There are patients who learn to manage their own tracheotomy tubes, for example.

In a meeting where problems of this nature were being discussed, a nurse asked how she might help a number of small boys attending cardiac clinic. These children, who were nine or ten years old, were obese. Orders from the physician were that they reduce. They were regular in clinic attendance and it had been possible for the nurse to see the majority of them at the same time during a clinic visit. As they gathered around the scales, she had tried to interest them in competing with one another to lose weight but with no success. On the contrary they seemed to be proud of gaining and boasted about their size. She tried, with appropriate aids and play material, to interest them in better diet but they bragged about the number of slices of bread they could eat at each meal. Because of organic impairment, the activity of all these boys was restricted.

Discussion of the problem at the staff meeting brought out that these boys came from a cultural group which often identified a fat child with a healthy child and considered it the role of a good mother to feed her child too well. Food was a symbol of life to them. All their children should have this in abundance, but especially the endangered and sick child. Deeper than this perhaps was the feeling on the part of the mother that it was not the child's fault that he was sick; she was herself to blame. It was also suggested that these boys could not play and compete actively with other boys of their own age for fun and prestige. If they had any special talents, we did not yet know about them. It was puzzling to know what inducement could be offered them that could counterbalance the strong infantile satisfaction of receiving food from their mothers.

A discussion group for the mothers was suggested and the

attempt to work directly with the boys on this problem was abandoned. An effort had been made to explain the need for careful diet to the mothers individually at clinic and some of these mothers had witnessed the nurse's attempt to work with the group of boys but none had changed her method of feeding her son. Some doubts arose in the minds of the nurses, however, as they discussed how they would initiate and lead this mother's group, since they could not have the services of a trained group leader. The anxieties of these mothers no doubt were great, probably deeper than even the mothers themselves knew. It seemed possible that a group built upon the present unsatisfactory progress of their children might add to their anxiety and increase the problem. On the other hand, the suggestion to these mothers that this was not an emergency might be reassuring and help them to accept the fact that the obesity if long continued would be harmful. As members of a group, they might gain reassurance from one another's suggestions, and satisfaction from making suggestions of their own. Also, the hesitation of the nurses to start such a group might be caused in part by their knowledge that the organic impairment of the children was irreversible and their fear of having to face this fact with the group if the mothers brought the matter into discussion. It was pointed out that the mothers probably were individuals of more resource than their children, and that they might have enough security in their general situation to be able to learn in and through the group to give their children a more varied "diet," not only of food, but of living. An alternative plan suggested intensive visiting of the mothers in their homes, which in this instance would be done by the same nurse who functioned in the clinic. The time-consuming nature of both plans was obvious. But as the nurse who presented the problem had seen, instruction and direct appeal could not "work" in this instance and something else had to be tried.

Direct appeal did not "work" in the situation just described because the children and mothers involved had little or no conscious understanding of the conflicts and resulting defenses that made them behave as they did. This was true also of the patients at the tumor clinic who knew that they could not assimilate what was being taught them, but were unaware that they were reject-

ing the diagnosis of malignancy with the irrigation can they left behind them at the clinic. The clinic nurse who takes full advantage of a well-administered, reassuring, and workable clinic set-up and then, when problems still arise, seeks the possible dynamics in the situation and is guided accordingly, can do much to make the clinic visit a constructive one for the patient, a visit which has ongoing strengths for future clinic contacts. With such a basis for work, the old term "delinquent," as applied to a patient who fails to keep return appointments, seems to miss the point. One dares to hope that this approach can also refocus the needs of some patients who come to clinic too often and too regularly, whose organic condition presents an ill-defined picture, and whose management in clinic eventually becomes routinized and unproductive.

Several hospitals in various parts of the country are attempting to treat, on psychosomatic wards and in psychosomatic clinics, patients whose condition does not present leading organic symptoms. The 1948 annual report of The New York Hospital describes the results of two years' work of such a clinic as follows:

During the past two years 889 patients suffering from emotional disturbance in relation to adverse life situations were seen in the psychosomatic clinic. Of these, 690 were followed for more than a year. The patients ranged in age from 5 to 69 years and presented in addition to their emotional difficulty the symptoms of such conditions as bronchial asthma, hypertension, vasomotor rhinitis, migraine, urticaria, hypoglycemia, dermatitis, peptic ulcer, mucous colitis, ulcerative colitis and phenomena of muscle tension. Of the 690 who could be followed, 113 were considered by their physicians to be symptomatically and basically improved; 234 were considered only symptomatically improved. Of the 343 who were unimproved, 191 attended the clinic for less than a month and of these 92 received no treatment. If those who received no treatment were excluded, 10% were basically improved, 38% were symptomatically improved, and 43% unimproved.

A variety of therapeutic procedures was employed, the greatest help coming from reassurance and emotional support of the physician and free expression on the part of the patient of conflicts and feelings. In some cases benefit was derived from advice concerning habits, attitudes and activities, explanation of psychophysiological processes, reassurance concerning the absence of neoplastic or infectious diseases, conference with other members of the family and attempts to modify life situations. Symptomatic drug therapy was helpful in some, in others free expression of emotions was aided by the intravenous use of sodium amytal and by dream analysis.

Great help was derived from the active participation of a most able member of the Social Service Department. An average of only nine hours per patient was spent and no patient received more than eighty-five hours of clinic time during the two years of observation. From analysis of the experience to date *it is possible to say that in a somewhat selected group in a medical out-patient department, fundamental and lasting improvement may be expected in more than half by the methods which may be employed in this clinic.* The most powerful therapeutic force stems from the ability of the physician to inculcate in the patient faith in himself and the capacity to recognize and deal constructively with his problems. This usually involves a reorientation of attitude and entails far more than a personal attachment to the physician. Only when he has acquired such faith and confidence is it possible for him to abandon the costly, inappropriate, emergency patterns and deal directly and constructively with threats and challenges of day-by-day living."

The psychosomatic clinic at Duke University Hospital co-operates with other clinics in the outpatient department and gives consultation and nursing service on the wards as part of a research, demonstration, and service project. Dr. Maurice Greenhill, director of the clinic, in cooperation with leaders in public health nursing in North Carolina and with the help of a nurse mental hygiene consultant, is using the center to orient public health nurses employed throughout the state to the purposes of mental hygiene. A number of other leading hospitals have established psychosomatic clinics and wards.

### CHILD HEALTH CONFERENCES

Perhaps some of us have grown so accustomed to "selling," setting up, running, and following up child health conferences that we do not always see them as the yeasty health activity that they are. However, one never hears a public health nurse—or anyone else—question the basic concept of the child health conference. One wonders why we gave up some years ago the name "well baby" or "well child" conference, and whether the old name—still used in some places—is not both simpler and stronger.

There are certain strengths inherent in well baby conferences. Mothers and babies come to the conference, which means that the mother has some degree of readiness for what can be learned there. Most of the babies are relatively "well" and therefore

the mother has some concrete evidence of achievement to present. The babies belong to the chronological age group that can react most quickly and enduringly to good care. We have an opportunity to observe, to approach mothers and babies with perception, and to fortify the relationship between them. Often the preschool child is also brought to the conference and we can observe his relationships with his mother and the baby and help with the problems usual at his age. The group reached by the child health conference thus grows in a natural way. At the conference the preschool children may experimentally make contact with one another. Sometimes this is their first opportunity to approach children of their own age. One mother observes another and watches the way other mothers respond to the situation and handle their babies. Thus a great deal of interaction is going on which, added to the help that mothers are given by the nurse and physician, makes the conference an important experience.

The conference serves an ever-widening group that grows in a natural way. The mothers who attend are not a complete cross section of the community but they do represent so large and varied a group that the community as a whole is influenced by what they learn about bringing up children. Few of the children who come to child health conference are ill or disabled and therefore their parents are more free to consider the small, satisfying incidents of daily life than are the parents of children who must be cared for in a special and taxing way.

Perhaps more vital than any other aspect of this work is the fact that *because the baby grows*, the mother feels the necessity for bringing him back continuously to well baby conference for information on how best to work with the increasing emotional and physical stature of her child. Natural growth creates an opportunity for care in contrast to the continuous demand made by the inroads of a disease. The care of the growing child is different, too, from that of the convalescent. Here, in a somewhat controlled situation, we have continuity caused by natural development. In the words of Dr. Walter Bauer, this is more than "passive health."<sup>12</sup> It is no anticlimax to say, accepting the wide range of the normal, that we do see babies in well baby conferences who are more puny than others, who have feeding difficulties,

who may be developing comparatively slowly or "differently," whose mothers do not always feel the urge for continuity of attendance at child health conference.

This natural, ongoing characteristic of the well baby conference has led to its use for study and research in child development and family relationships. Among a number of such projects, well known to us, are the work of Dr. Margaret E. Fries in well baby clinic at the New York Infirmary for Women and Children; Dr. David Levy's participation in a child health conference of the New York City Department of Health; the participation of Dr. Frances Ilg, of the former Clinic of Child Development, New Haven, Connecticut, in local well baby conference; the work of Dr. Paul Lemkau and his staff in the Eastern Health District in Baltimore; and that of the late Dr. C. Anderson Aldrich in Rochester, Minnesota. The latter shows in some aspects almost amusing proof of the vitality of the child health conference. The staff of this project intends to follow the children seen in the conferences up to the age of twenty-one for study and possible verification of the concepts and methods used. But new babies keep coming into the situation. The result, one understands, is a pyramiding of opportunity that is a little startling even to the project staff itself.

Other careful research projects associated with well baby conferences are now in beginning stages. At some future time we shall be able to read the results of their studies of growth and development. If one talks with public health nurses who are participating in these projects one realizes that they are observing the patients with new understanding and that little facts come to have more and more meaning to them. "One mother always holds her baby out away from her." "One baby never smiles except occasionally very faintly and, the mother says, never has. He seems to reflect the sadness in the mother's own face." "A preschool boy who came to the conference never seemed to know that his baby brother was there, even when they were in physical contact." "The baby had a dirty neck. The mother was so uneasy for some reason on this first visit that I decided not to point it out to her and show her how to wash it."

We can take pride in the attitudes and methods of nurses in many of our well baby conferences. It is here that the valuable



"developmental record" has had its greatest use and that we have tried to use our knowledge of normal growth. We know that we must add to this as opportunity permits. Already we recognize that normal development includes not only gain in size, improved nutrition, and maturation of the body systems and resulting motor skills, but combined with this, the way in which the child begins and continues to use himself as a separate person in relation to other people: There is still some reliance on our part on what the anthropologist might call "magic" in our teaching in well baby conferences. That is, sometimes we still offer to mothers so-called facts or axioms that have become almost a ritual with one or another of us because they have been used so often, though the actual usefulness of such information may need re-examination. Occasionally we take refuge in such axioms defensively because we do not feel well informed on the subject about which the mother asks. Also, some of us may become somewhat panicky as we realize the importance the well baby conference has — not only in our own minds but in the minds of other professional groups. However, if we become frightened at the magnitude of the opportunity and the responsibility, we shall do less well than we have in the past. Perhaps we can trust ourselves to grow slowly and soundly along with our child health conferences.

## NURSE AND MATERNITY PATIENT

In some ways it is illogical to offer a separate chapter on the work of the nurse with the maternity patient. To do so may seem to isolate the experience of maternity from the patient's other experiences and, by the same token, to differentiate the service which the nurse gives from other aspects of nursing care. Writing along this line about the antepartum period, Dr. M. Edward Davis says:

One can no longer plan for the care of women during pregnancy without planning for their general health, the prevention of disease, and the subsequent care of their children. Adequate prenatal care today is the best type of preventive medicine. It includes a careful and complete physical examination to uncover incipient or obvious disease. It should include an X-ray of the chest to rule out tuberculosis, the care of the teeth, a complete examination of the blood to detect syphilis, anemia, and to determine the RH factor, and X-ray pelvimetry to determine the adequacy of the birth canal. Prenatal care is educational for it should teach the mother the essentials of nutrition, the care of herself, and the care of her newborn baby. Thus, it represents a cross-section of modern medicine with emphasis on prevention rather than cure.<sup>24</sup>

The nurse does not disassociate the maternity period from other health problems of the mother or ever think of the mother during this period apart from her family. However, although the patient reacts to her pregnancy according to the kind of person she may be, new factors are added at this time, some temporarily, some permanently, which create a special situation. The maternity cycle seems also to act as a precipitant, bringing out whatever assets or difficulties already exist. The old saying that a pregnant woman is "herself, only more so" seems to apply here.

Maternity nursing appeals to many public health nurses. Here the nurse comes close to the roots of our population. The newborn infant represents a fresh start, even though heredity and familial attitudes and customs link him with previous genera-

tions. Often the family feels this new impetus. If the nurse has children of her own or would welcome them, she finds this phase of her work satisfying so long as she safeguards her relationship with the patient by some understanding of her feelings.

However, perhaps just because work with maternity patients can be exceptionally satisfying, it can also be very discouraging. One hears discouragement or dismay most often expressed by public health nurses who work very intensively in a given community and have little opportunity to see or hear about the maternity health program as it functions nationally or in a state or area. All surveys show us that the maternity program is "spotty" as one compares one state with another, rural areas with urban areas, and one racial or economic group with another. If a nurse is working hard, with the odds against her in a relatively deprived community, it is difficult for her to gain the perspective that comes from seeing the scope of the maternity and child health program as a whole. She is only too well aware, to quote Dr. Davis again, that "It is this segment of our population [the underprivileged one-fifth of the number of pregnant women] which has the highest birth rate, the poorest economic level, the highest maternal and infant mortality."<sup>21</sup> She knows that it is almost impossible for many of the families with whom she is working to welcome another child. She is concerned because children in these large families may have to share the attention of parents and other basic elements of security such as food and shelter, to the point of meager living and actual hardship.

The picture is different, although elements of discouragement also exist, for the public health nurse in areas where there is greater economic security or where medical resources are adequate. For instance, in a so-called sophisticated urban area, pregnancy is often unwelcome, in spite of relative abundance of time, money, and medical resources, because it interferes with personal or family plans or because it conflicts with some individual attitude on the part of the mother.

Therefore, all public health nurses need close contact with maternity and child health consultants or with other informed supervisory staff so that they may know the maternity situation for the nation as a whole, and the plans and possibilities for

areas such as their own. Leaders in this field agree that no one plan of organization is appropriate to all communities. Programs and methods should be and have been adapted to the locality in which they operate. Ruth Taylor, Director of the Nursing Section, Division of Health Services, Children's Bureau, summarizes the work of the nurse in a number of these programs.<sup>100</sup> She also emphasizes the need for more public health nurses with additional training in maternity work, including midwifery, both to help in carrying out the program in health centers and to aid in the organization and consultation aspects of the programs.

In considering personnel one is constantly reminded of the shortage of obstetricians and consequently of the burden which must be carried by general practitioners. *America's Health* reports:

There are less than 1,900 obstetricians certified by the American Board of Obstetrics and Gynecology. Nearly half of these are in the twelve metropolitan areas of over 1,000,000 population. Two states have only one certified specialist in obstetrics; four others have only two each. The total number of doctors who limit their practice to obstetrics is 4,076. General practitioners with varying degrees of training in obstetrics deliver a large proportion of the mothers and usually without recourse to assistance when needed from specialists.<sup>101</sup>

If it is true that we use our energies to better advantage and are less unrealistically disheartened or encouraged by local conditions when we see the problem of maternity care broadly, statistics which show progress over the last thirty years, and especially during the last decade, are appropriate here even though this information is readily available elsewhere.

The past decade has witnessed phenomenal changes in maternal and child health in the United States. Each year since 1935 there has been a progressive decrease in the hazards which beset mothers in childbirth as well as their newborn babies. In 1935 some 58.2 mothers in every 10,000 women who gave birth to living children did not survive to raise their offspring. In 1945, the last year for which official vital statistics are available, this figure has been reduced to 20.7. Unofficial figures for 1946 and 1947 indicate a continuing downward trend in maternal mortality. The saving of lives can be better visualized in the total figures, for in 1935, 12,544 women did not survive their pregnancies whereas in 1945 these figures had been reduced to 5,668, in spite of a 25 percent increase in total births.<sup>102</sup>

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A summary of the larger factors responsible for this improvement is given in *America's Health*:

The quality of obstetric care given by obstetricians and general practitioners has been responsible in a large measure for the great progress in the past decade, aided by such advances as the sulfas, penicillin, and streptomycin, the wider use of blood transfusions and plasma, X-ray examination of the pelvis, better nutrition, and higher qualifications for the training and licensing of midwives. The emphasis on breast feeding and on rooming the mother and baby together in the hospital, the growing concern for emotional security of mother and baby and the whole family, newer methods of anesthesia, and the growing interest in natural childbirth—all these have contributed to improving the health and well-being of mother and baby.<sup>23</sup>

The preservation of the lives of mothers and babies is of paramount importance to any country. Furthermore, the mother's ill health or death weakens the family group or destroys it and, like the pebble dropped in the pool, affects a wide circle of people. For such reasons funds and personnel have been available for as careful and complete surveys as can be made. The fact that there is authenticated knowledge of the situation as it is now with regard to maternal and child health, that there are possibilities for the community organization of programs which seem feasible, and that technical knowledge has advanced means that any maternity work which the nurse does can increasingly be linked to resources that are of proved value. The nurse's knowledge of human behavior helps her to understand the administrative problems involved in setting up and maintaining a program appropriate to her community, and to recognize the difficulties and attitudes of those responsible for the program. But no understanding of human behavior can take the place of medical resources.

No matter how good an understanding the nurse may have of the emotional needs and difficulties of the maternity patients with whom she works, successful work from a mental hygiene point of view necessitates a workable, available program for the instruction and care of mothers, or the prospect—not too remote—that such can be set up. Granted the existence of such a program, the public health nurse will be able through instruction and care to help the pregnant woman understand what is offered and how to use this help. It is interesting, however, that even

when they know that excellent resources exist, many pregnant women are unwilling to avail themselves of this help. Through her individual work with these patients, the nurse will understand the attitudes and emotional difficulties that are blocking them. There are other prospective mothers who, while accepting the safeguard of medical care, need consistent contact with the nurse to confirm what they have learned, to help them in making plans, and to give them an opportunity to discuss the emotional problems that may be besetting them.

### ANTEPARTUM PERIOD

The prenatal visit can be no stereotyped affair whether it takes place in the clinic or in the home. When a survey of public health nursing was made in 1931-1932, it was found that the prenatal work of the nurse, as far as home visits were concerned, led in quality the seven nursing services. The survey offered the following reason for this high performance:

*The content of the prenatal visit has been so definitely defined that it can be easily learned by the nurse, no matter what her experience in prenatal care may have been as an undergraduate student. A prenatal visit . . . involves definite points of instruction and observation for specific periods during pregnancy. . . . There is, therefore, specific and tangible content for the nurse to learn and to apply in her prenatal service."*

We now realize that, like many statements intended to be interpreted broadly, this comment can be taken so narrowly as to make a prenatal visit seem a routine affair. Such an attitude breeds resistance in the patient and dissatisfaction in the nurse. We all know that pregnancy is an individual experience and we are not satisfied to use the same methods in all prenatal visits. We feel the need for material suited to each patient—the mature, informed woman as well as the inexperienced girl. Some of the "specific content" we have acquired may be appropriate at one time but not at another; some of it may be usable with one patient but not with another. Again we see the usefulness of a sound body of technical information which can be applied flexibly to the needs of the individual, as the patient shows us, in ways he may or may not realize, what his needs are.<sup>29</sup>



*Emotional Reactions Related to the Pregnancy Itself.* Profound physiological changes take place in all pregnant women and these changes have an emotional accompaniment. We understand that pregnancy is a normal, physiological process. Sometimes we may confuse "normal" with "insignificant" without quite realizing that we are doing so. "No organ escapes the stimulus provided by gestation," Dr. Ruth A. Rohishaw said in an address on the significance of maternal health. The statement has been made that, although pregnancy is a normal physiological process, no process can so quickly become complicated or pathological.

The emotional difficulty sometimes experienced by a woman in the first or second month of her pregnancy may be a normal accompaniment of physiological change. When the nurse visits the patient, she may find her in despair, railing against her fate, and sometimes even ready to injure herself to escape from it. She is not interested in a medical examination. Financial worries and other family problems assume greater proportions than ever. The woman is like a creature in a trap. The nurse feels that now, if ever, she has a problem on her hands. She returns for the next visit with some trepidation, often to find the patient serenely going about her daily life, of which the pregnancy seems to have become an accepted part.

Keeping in mind the reason for at least part of this phenomenon, the nurse is better able to help a distressed woman when she finds her at the height of her physiological reaction. It would seem to be no time to enlarge on the beauties of motherhood; no time to take too seriously the patient's discussion of her husband's shortcomings. Neither would it seem appropriate to attempt to argue the patient out of her prevailing mood. To the patient, her mood is reality. If the nurse has not experienced pregnancy herself, possibly she may understand the patient's conviction that life is generally hopeless from her own occasional depression before the onset of menstruation. At this time she feels that her former optimism was ridiculous, that now she sees clearly. Then she finds she has been merely a victim of another, if less far-reaching, normal physiological process. When the patient is in this mood, perhaps the nurse can assume the

role of listener. She will understand that her job of interesting the patient in regular medical care or of helping her to institute a regime for the pregnancy may meet with greater success in a subsequent visit. However, there is some indication that the patient's anxieties may mount in the third trimester.<sup>57a</sup>

There is not complete agreement that many pregnant women experience marked changes of mood. The study, *Anxiety in Pregnancy and Childbirth*, previously quoted in connection with mothers' clubs, reported that while all but three of twenty-seven women studied showed mood changes, these were "not usually marked, although in a few instances they were conspicuous." It was also shown that the severe mood changes occurred in women who had experienced such upheavals prior to pregnancy.<sup>57a</sup>

Although the pregnancy may have been planned and the baby may be anticipated with happiness, the early months of pregnancy are likely to be a period when the patient is more than usually introspective because she is preoccupied with her own sensations and emotions. During the later months, a new physiological balance has been achieved and tissues are being built up and reserves stored for the nursing period. The late months of pregnancy are commonly ones of anticipation when the mother is planning for the time when the baby shall have arrived and is receptive to thoughts of the future. This is often the right moment for the nurse to make suggestions as to layette and trays, and to consider the care of the baby. At best, however, this is a generalization and the nurse may find many exceptions to it. Sometimes, when a mother shows great pressure to accomplish the details of preparation as early and as fast as possible, the nurse recognizes a symptom of anxiety. She may find that the mother who has her trays and supplies prepared during the first few months of pregnancy is the tense pregnant woman rather than the woman who is a "quick learner."

Hopefully, the path of the pregnant woman will be a fairly smooth one either by reason of fortunate circumstances or because of the woman's strengths. Nurses who have been working with pregnant women for a long time will recall the firm belief of earlier times in prenatal influences, will remember the reaction of denial of such direct influence on the embryo, and are aware of the current acceptance of the influence of the mother's physical and emotional state upon the unborn child. In an early chapter

of *Mind and Body*, Dr. Flanders Dunbar writes:

As yet no one knows very much about the effect upon the child of the mother's mental and emotional experiences during pregnancy. There used to be an imposing volume of legend which attributed to these experiences all sorts of peculiarities. . . . Exaggeration caused a healthy reaction, but we are swinging back now to a realization that there is such a thing as prenatal influence and we must set ourselves the task of finding out what it is. . . . Enough is known now to prove that both physical and mental characteristics depend to some degree upon experiences in the prenatal period. . . . There is also good reason to believe that if the mother is subjected to severe emotional strain during pregnancy, it may have an effect upon the unborn child. This may be in part because of a change of nourishment due to chemical reaction; it may be in the transmission of more subtle influences between mother and child.<sup>44</sup>

A common reaction to pregnancy is fear. Since at present the danger that the mother will die cannot be eliminated entirely from any of the three periods of the maternity cycle, this fear is to some extent founded on reality. However, the experience that many women are having today with the method of delivery known as natural childbirth suggests that fear of death and the fear of pain can be considerably lessened and perhaps eliminated entirely in pregnant women who are prepared for delivery by this method. Many of us have known numbers of women who have had babies by natural childbirth. If fear has been a part of this experience at any time, it seems to have been only the kind of fear that any decently humble human being knows almost daily in meeting the heavy demands of a job or some crisis of daily life. By practice and writing, the British obstetrician Dr. Grantly Dick Read has done much to stimulate the use of the natural childbirth method in this country. It is so successfully used here, however, that one sees it does not depend on an unusual gift for working with people such as Dr. Read possesses.

Many of us at least have a grasp of the theory on which this method is based. Delivery is not considered as a dangerous, traumatic crisis but rather as a natural piece of work for which the mother can prepare herself, physically and emotionally, during pregnancy. Relaxation helps muscles to yield; anxiety on the other hand tightens muscles so that mother and unborn baby fight each other during the necessary enlargement of the cervix, resulting in pain for the mother and in some degree of exhaustion

for the baby. The prenatal period is a time of specific training in methods of relaxation, in building muscle tone, and in appropriate use of the body. During the early stages of delivery the mother is followed closely, reassured, and reminded if necessary of the methods she has learned. Her husband is with her and helps her instead of being relegated to the corridor or solarium. The mother is fully conscious, she participates during all stages of labor, and is given her baby immediately upon delivery, before the placenta has been delivered. The mother who has her baby by natural childbirth no longer need experience the comparatively slow recovery from a generalized anesthesia. She is very tired after delivery, but there is a difference between the exhaustion caused by pain and that which follows voluntary expenditure of all the strength and energy one possesses, without pain.

Not every woman can undertake natural childbirth. A certain body build, freedom from physical impairment such as organic heart disease, and the security that comes from satisfactory habitual attitudes and relationships are prerequisites. Mothers who request delivery by this method are therefore examined and studied carefully before they are encouraged to undertake it. Perhaps it could be said that these are the mothers for whom delivery would be less painful and frightening anyway.

At the present time there are only a limited number of places where delivery by natural childbirth is demanded or in use. For this reason, and because only a selected number of women are able to benefit by it, the majority of women still deliver their babies in pain or under anesthesia, and with varying degrees of fear, conscious or unconscious, during the antepartum period.

Fear can be as diverse in its causes and symptoms as the personalities of the patients themselves. Some women literally do not know what is taking place within them or how the baby will be born. We still find women who think the baby will be born by bursting through the abdominal wall if the physician is not at hand to deliver. Of these women, perhaps not all are merely ignorant of simple anatomy. Not long ago this misapprehension was discovered in a college woman who had successfully passed courses in biology which included laboratory work, but who had not faced the facts of human reproduction, perhaps because of her personal difficulty in accepting their sexual nature. However,

through her knowledge of anatomy and physiology, the nurse will know how to reassure the uninformed patient by simple explanations and can urge the further reassurance that comes from medical examination.

Superstitions relating to pregnancy are often a source of fear. Superstitious beliefs die hard and cannot always be uprooted by scientific explanations. In fact, there are so many instances of marked babies that we ourselves cannot honestly say that we are unmoved by the superstition. To rid ourselves or our patients of obstinate doubts we turn to our scientific training. We can offer to the patient the facts of anatomy and physiology, realizing that no mere "wipe-out" of the old concept by the new can be achieved, and yet that as new ideas prove their worth useless superstitions may lose their power to cause fear. The fear of marking the baby is worth dispelling when we can do so, for not only is it a burden to the mother, but it means that the baby grows up in a home where it is believed that mischance has touched him and perhaps will continue to follow him.

If some member of her family or her husband's family has had a physical or mental illness and the mother knows that the illness or a tendency to it may be passed on to her baby, her fear may have a basis in reality. In such cases, accurate knowledge on the part of the nurse, and medical advice, can be helpful.

We know, however, that fear for the baby's condition may result from a variety of other causes not so easy to recognize. For example, the patient may suffer from a sense of wrongdoing or may be afraid that she has injured herself or the baby because she has attempted an abortion or used contraceptives. She may not tell the nurse why she is afraid but the nurse is often able to trace such fear to its source and to allay it with actuality. On the other hand, fear may have no such direct tie-up. It may result from guilt about sex matters in general, perhaps due to the manner in which a woman first received this information or to conditioning experiences previous to or early in marriage. Such a feeling of guilt does not always sail under its true colors. Sometimes it appears as a vague anxiety about things in general. Sometimes it underlies physical symptoms for which no organic cause can be found. In extreme instances, when the patient is in deep conflict between her sense of guilt and the fact

of her pregnancy, an actual neurosis or psychosis may develop. Anxiety of this kind often explains why a woman resists her pregnancy and at the same time the services of the nurse. It has been suggested, on the basis of study, that a tendency to worry about a number of apparently unrelated matters may be "a dependable index of basic anxiety proneness."<sup>67a</sup>

Many patients have had experiences with former pregnancies that definitely condition them for or against the present pregnancy. One can understand that a woman whose previous labor has been exceptionally difficult, who has been delivered of a stillborn child, or who is beyond the usual childbearing age may well be afraid of labor both for herself and for the baby. However, this is hopeful ground for the nurse. Careful medical and nursing supervision and class discussion can help to allay the fear. And if a "good" baby is successfully born, the particular bugaboo may be laid forever.

In a study of primiparae, eleven reasons that mothers gave for not wanting a baby are listed.<sup>68</sup> The word "fear" appears four times among these reasons and might have appeared oftener if the replies had been discussed with the mothers and further analyzed. The four fears were: fear concerning heredity; superstitions and fear of markings; fear of pregnancy and delivery; fear of effect of birth control.

*Emotional Reactions Related to Personality Pattern or Particular Strains.* It would be misleading to attempt to list or discuss a series of problems specific to pregnancy other than those dependent on physiological changes, and perhaps those based on fear. One even hesitates to include problems based on fear because patients show this emotion in such a variety of direct and indirect ways. To set up a list of problems as specific to pregnancy would be to isolate a certain period in the life of an individual, limiting cause and effect to the nine months of pregnancy. A cross section of the experiences of the nurse with many pregnant women, while showing conditions which repeat themselves often enough to need study, has a limiting effect on the nurse's attitude toward the individual patient.

On the other hand, a longitudinal section of the life of the individual maternity patient may be more revealing and clarifying. In other words, it seems of more value to study each pregnancy

in relation to the mothers' personality pattern and to the whole situation of that mother and family than to fit our thinking around certain formulated problems of pregnancy. This approach later helps the nurse to understand the individual mother's methods with her children. If the nurse's relationship with the family continues, she will be helping this same individual to meet still other situations. She may find she was wrong in some of her previous thinking, but new developments will always be related to what has occurred. A long-time view also helps the nurse to avoid overemphasis on this phase of the mother's life. Dr. Frederick W. Dersheimer, writing on this subject, suggests that society has made it difficult for women to accept pregnancy naturally. "The same amount of attention to eating would make most of us have nervous indigestion."<sup>33</sup>

What kind of woman accepts and carries through a pregnancy with serenity and happiness? What emotional stability need she have achieved? One might suggest that she needs to be mature emotionally to the point where she welcomes a pregnancy because she wants a child for its own sake, has no anxiety or guilt concerning the sex relationship in marriage, and, in general, has the ability to solve or if necessary to carry her conflicts and problems without too much strain.

It is obvious that one can achieve physical maturity without being mature emotionally. A woman may be well on in pregnancy or have borne several children and still be emotionally a child. Perhaps the mother is still very much her mother's or her father's daughter; perhaps, as substitute for these parents, she unconsciously needs her husband's protection and direction as a father. It would be difficult to welcome a pregnancy if one unconsciously wanted to be a daughter rather than a mother.

Familiar situations begin to fall in line as one carries this thought along. We remember the young mother who became unreasonably irritated with her husband during pregnancy and spent most of the time at her own mother's home. We remember the mother who felt during pregnancy that she should be "babied" by her husband and other members of the family, that every whim should be satisfied. There is the mother who, the

record states, "acts like a baby herself." We recall the mother whom the nurse described with accuracy as treating her new baby "like a doll," interested in the dainty layette but quickly tiring of the baby's care and frightened by the slightest emergency. Again, there is the mother who relies on her own mother or on the nurse for decision and planning, or who refuses to allow planning for the coming baby to break into a formerly carefree existence. Sometimes the emotionally immature woman will grow up into motherhood; sometimes she fails to do so. Under such circumstances, many times the nurse must weigh carefully the degree of responsibility which she or another appropriate person must assume temporarily, or permanently. Even a stable, mature woman may need the nurse as a temporary "mother," especially during the first months of her pregnancy and if, for instance, she is a stranger in the community or a newcomer to the country, her old relationships broken and her new ones not yet strong enough to give comfort and support.

Anxiety and guilt concerning the sex relationships in marriage, sometimes symptomatic of emotional immaturity, present a problem the nurse often has to face in her work with the maternity patient. In speaking to a group of nurses and social workers in Cleveland, Dr. Oscar B. Markey described the factors underlying this aspect of emotional maturity in a way that is clarifying to us. He said in part:

When we speak of mature people, we mean those that actually are able to get along comfortably without their parents and comfortably with them — people who have reached a point where they are able and, in fact, anxious to leave home to re-establish themselves in a new kind of family life. . . . They have been helped to accept their functions sexually so that they feel comfortable when the subject of sex is discussed, and activities of sex have to be faced and experienced. . . . Those people have a feeling that they are complete through a mature heterosexual relationship; that all other types of adjustment represent a substitute effort which is not easily successful.

Here, too, familiar situations come to mind, perhaps with additional meaning. Is it more than modesty or tradition that hinders the mother who is "ashamed" to go to a physician for examination during pregnancy? Have we an inkling of the source of conflict of the mother who said during her first pregnancy, "It makes me sick at my stomach to think of nursing the baby."



Sometimes the underlying factors are reflected indirectly in fear of the pregnancy or in rejection of it. An example, taken from a nursing record reads:

Mrs. S. is seven months pregnant. Does not want the baby. Says she will not nurse it. Thinks the idea of breast feeding "disgusting." Says she is a rather frigid person and that her sister is the same way. She never did like "petting." Now it makes her sick when her husband comes near her.

The nurse who visited this mother had recorded the mother's comments as interesting and, to her, unusual, but she did not understand their connection with the mother's unwillingness to follow the usual preparation for breast feeding. When the case was discussed in staff conference it was suggested that it might be appropriate, if the physician approved, to substitute bottle feeding without further emphasis on the advisability of breast feeding.

To dub this or that patient emotionally immature may be to "diagnose" and may bring us a certain relief because we have found a category in which to place a difficult patient; it may also be our refuge in a moment of inadequacy. On the other hand, the value in the nurse's awareness of such emotional factors lies in her recognition that she has here an added means for meeting the patient's needs. Emotional immaturity may explain an unwanted pregnancy, for example, and in turn, the patient's lack of interest in what the nurse has to give, or perhaps her actual resistance to the work of the nurse. Similarly, emotional immaturity may cause the patient to seek dependence on the nurse.

Poverty, and the attendant problems of bad housing and overwork, poor physique, frequent pregnancies, and the breakdown of marital happiness under these and other strains can combine to exhaust the physical and emotional reserves of any woman. The nurse cannot help being concerned by these reality situations. However, it may be pointed out here again that no life can be considered apart from the person who is living it. Whether circumstances are tolerable or intolerable, remediable, partially remediable, or hopeless depends to a large extent on the personality of the individual who is called upon to face them.

Nevertheless, a group of pregnant women who lived in a large

city evidenced clearly that their attitudes toward having a baby were influenced by the immediate environmental situation. They had wanted to get their bills paid, to find adequate housing—a place of their own—before becoming pregnant.

As has been stated, not a few mothers frankly reject the whole pregnancy. It is less painful for the mother whose baby is unwanted to think about her condition as little as possible and to put off making plans as long as she can. If the nurse accepts without surprise or disapproval—or concurrence—the fact that the mother does not want her baby; if she feels no need to reassure the mother that she will soon welcome the pregnancy, the patient may feel that she has found someone who really understands her difficulties and who is interested in her personally—not exclusively in the coming baby or in what is to her a vague community health enterprise. She need not “pretend” to the nurse. Because she feels at ease with her, she can see the situation more objectively. She may feel that it will be just as well to have the nurse continue her visits since, after all, the baby really is on the way.

The patient's rejection of the pregnancy may take the form of apathy and indifference. Perhaps she is too depleted to care what happens to her. Or she is too busy with her housework and other children to think about her own needs. She may be dulled emotionally or inadequate intellectually to the point where she is incapable of thinking about tomorrow with imagination or energy. A nursing record gives an instance of such a patient. According to the identifying data, the patient was a woman of forty, born in Lithuania, the mother of eight children. “Mrs. B is six months pregnant. She will not plan. Just shrugs shoulders. Very apathetic and not alert. Abdomen is pendulous; posture poor. No medical examination.

In situations like this, with the stage set for the complications of pregnancy, the nurse not only feels baffled—she is frightened for the safety of the patient. She feels her professional responsibility strongly. Perhaps she forgets that no efforts of hers will make this woman over into a person who completely accepts scientific medical care for herself and her household. The nurse

are inexcusably indulging themselves by their behavior; or we reveal a similar lack of understanding by rushing to the defense of the patient against what seems to be an accusation. An instance of the latter attitude is available in which the nurse knew patient and family long enough to see the story rounded out. A woman of forty-two who had six living children, the oldest of them a married daughter, became pregnant. At first she was openly resentful and "ashamed." She wept and appeared very unhappy. Gradually she did less and less housework, relying on her husband, who worked nights, to carry this responsibility. She became dizzy and vomited frequently. Presently she began to spend most of the day in bed, though the clinic which she attended had not recommended this. The nurse was more disturbed over the physical symptoms of this late pregnancy than over the possibility that these symptoms could represent a last rebellion against the pregnancy, and felt that the clinic conceivably had withheld help which the patient needed. On the nurse's next visit the patient was not at home. She had found herself a job "working in tobacco." She explained when the nurse next saw her that she wanted to forget the baby. She continued this work for four months without any physical discomfort whatever, giving it up only when time of delivery approached. The mother was delivered of a healthy boy baby. Neighbors and friends visited, bringing gifts and admiring the baby. The mother was proud of him. She said to the nurse, "How do you suppose I could have not wanted him and made myself so miserable about it?" Later the baby had pneumonia. When the nurse visited to assist in his care the mother said, "I suppose I am being punished for not wanting him before he was born. None of the other children ever had pneumonia." This illustration even in its bare outline suggests a rejection of pregnancy showing itself in probable conversion symptoms, the difficulty of the nurse in accepting the symptoms as such even though the patient had the protection of medical care, and the carry-over of the mother's antepartum attitude in her feeling that she was being punished by later events in the baby's life.

These circumstances did not work out disastrously. Sometimes, however, a deep resistance to pregnancy persists, so intense as to include rejection of life itself. We know that consciously or

unconsciously the mother may wish to die to escape from what is, to her, an intolerable situation. In fact, as we know, she may bring about her own death.

It seems obvious that many mothers who are unable to offer either health or a secure family life to their children become pregnant, and that women who might well hear children are not doing so. In fact, the nurse herself may be one of the latter, which may complicate her own attitude and that of the patient in a way she may not recognize. Granted she can help the mother by accepting the fact that the mother does not want her pregnancy, she may also be able to stimulate the courage and energy of this mother if her own attitude toward the carrying on of life has achieved some measure of authentic buoyancy with which the mother can to a certain extent identify.

In contrast to the women who reject a pregnancy, there are others who "overwant" their babies. On first acquaintance with these patients the nurse may feel that the welcome given her offers an opportunity for the enriched program previously mentioned. Or she may fear that here is a mother who will welcome dependency on the nurse. Further observation may lead her to think that the mother's eagerness is a neurotic reaction; here, instead of encouraging this attitude because of her pleasure in a receptive patient, she will help to establish in the patient a better emotional balance so that she will feel her pregnancy is only one of the important factors in her life.

Mothers who have waited years for a pregnancy are among the outstanding examples of this attitude. Illustrations at hand vary from the woman whose five-year wait for a child resulted only in good care of herself during pregnancy without oversolicitousness for the baby, to the following extreme example of an "overwanted" pregnancy. A Jewish woman of thirty-five had been delivered of a stillborn baby fourteen years before. No subsequent pregnancy occurred until the recent one which, the mother believed, took place because she had asked a rabbi to pray for her. In gratitude for this the mother pledged herself to send money weekly for the rest of her life to help the rabbi's work in "the old country." The baby was delivered by Cesarean

section following a pregnancy during which the mother requested almost daily calls from the nurse and visited her physician more often than he thought necessary. The baby boy showed feeding difficulties and temper tantrums which were obviously related to the mother's tension and oversolicitude. A succession of physicians whom the mother consulted tried to make this clear to her. In fact, one pediatrician suggested a temporary placement of the child away from home. After four years of accepting and understanding the mother's terrific sense of responsibility, the nurse reported that the mother had become sufficiently relaxed to allow the child to feed himself and to play out of doors without her.

It would be superficial not to question, in turn, the cause of this overemphasis on the part of the mother. In this Jewish mother its origin might lie to some extent in the racial tradition which expects a woman to produce sons. Family relationships form the background for other instances. Perhaps the mother feels, consciously or unconsciously, that a child will take the place of an unsatisfying relationship with her husband. Another situation, frequently observed, is overemphasis on a pregnancy which the mother realizes will be her last because of the death of her husband, because of her own health condition, or because she is passing the age of childbearing.

### DELIVERY

The public health nurse's actual delivery service is centered in the home delivery. Again we are confronted with the unevenness of resources and practice throughout the country.

The high tide in the number of births in the United States was reached in 1947, with 3,910,000 babies born. Nearly 80 per cent of all these babies were born in hospitals. Eighty-four per cent of white mothers had their babies in hospitals, as compared with only 40 per cent of non-white mothers; 2 per cent of white births were unattended by a physician, whereas 38 per cent of non-white had no medical care. City dwellers had 91 per cent of their babies in hospitals, but in the country this percentage fell to 61."

Thus, one talks with a nurse in a certain medium-sized eastern city and finds that one hundred per cent of the deliveries in her current maternity case load take place in hospital. One talks with

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Thus, one talks with a nurse in a certain medium-sized eastern city and finds that one hundred per cent of the deliveries in her current maternity case load take place in hospital. One talks with

a nurse in a certain area in the South and finds that home delivery has been an established and accepted custom for generations.

If delivery is to take place at home, the nurse will have helped the mother to prepare room and supplies, will know what assistance can be expected from members of the family and others, and what plans have been made for running the household while the mother is unable to do so.

The nurse knows that there is a margin of safety in preparation for delivery below which she cannot work except in case of emergency. However, the question whether a mother is prepared for delivery is not one that is answered easily or in a routine way. One mother may have everything ready as far as the physical environment is concerned but be less prepared in strength and serenity than another woman whose plans for delivery and household remain incomplete. The latter may deliver easily by "natural childbirth" though she has never heard of that method of delivery.

Labor and delivery is the focus of any fear which the pregnant woman may have, whatever the causes of the fear. The fact that simple explanation of the anatomy and physiology of pregnancy helps to allay the fears of pregnant women has been mentioned. The experience of all nurses shows this to be true. However, our current instruction shows a change in emphasis. We give this instruction not only so that the mother may know what is happening to her and the baby during pregnancy and delivery and what she may expect in the way of symptoms and feelings, but also so that she may know how best to use her bodily and emotional resources as delivery approaches and during delivery. Sometimes in the past we appear to have been most interested in helping the mother to guard herself and the baby against harm. Such matters of hygiene as height of heels, suspension of garments, good judgment in the kind of work performed, have been, and are, important. However, we are learning more now about ways in which a woman can learn to *use* her body in pregnancy and delivery in addition to protecting it.

#### POSTPARTUM PERIOD

The work of the public health nurse during the postpartum period is greatly influenced by the trend toward hospital delivery



and the immediate after-care for mother and baby provided by the hospital. The fact that the majority of babies the country over are born in hospitals means that many public health nurses are not present at the delivery of patients with whom they work, and therefore that increasingly close correlation between public health nursing agency and hospital is needed during the antepartum and postpartum periods if consistent service is to be given the maternity patient.

There are special current aspects of this correlation. We realize that there is a shortage of maternity beds in hospitals and that during the second World War both lack of beds and lack of personnel, as well as new medical findings, led not only to early ambulation but to early discharge from the hospital. It is small wonder that many of us have confused early ambulatory care with early discharge and may have thought the two to be one and the same thing. During the war and in the period immediately following, public health nurses sometimes found postpartum patients and their babies at home, discharged from hospital, before mailed report of delivery reached the nurse. As better methods of reporting developed, the public health nurse accepted a heavier load of actual postpartum nursing as a necessity. Hospitals are still crowded but there is an increasing differentiation between early ambulation and early discharge. The patient is no longer routinely discharged on the third day. As practice increasingly steadies down in this respect, the public health nurse can expect to find postpartum patients nearer their normal status on return home than was true in the old days. Again this will vary with the individual patient. It is now realized that "third day postpartum" or "sixth day postpartum" is not a sufficiently individualized summary. More judgment of the patient's condition is required of the nurse as well as of the physician. One well-known obstetrician believes that postpartum care of the maternity patient is largely a nursing responsibility.

Unfortunately, it has not always been possible for the public health nurse to visit the home promptly after the return of mother and baby from the hospital. This is perhaps especially true during some of the winter months when nursing care of patients with acute upper respiratory infections and the like is heavy. Prompt follow-up is sometimes difficult during the summer

months too because of vacation schedules. Nurses express a feeling of considerable conflict over the fact that they often have to make a choice between bedside care of a sick patient and a visit to a newborn baby and his mother. Sometimes a month or more goes by before the latter visit can be made. We are sincere in our appreciation of the importance of this period for both mother and baby and in our belief that the nurse can be helpful during these early weeks; our inability to carry out our function is thus a deprivation both to the family and to the nurse herself.

We may find some mothers handling and caring for their first babies in a surprisingly accustomed manner when we enter or re-enter the situation during the postpartum period—and new fathers showing much the same ease. These families have made many of the necessary early adjustments while mother and baby were still in hospital due to the “rooming-in” plan. Like the theories and methods of natural childbirth, the literature on rooming-in is becoming widely known throughout the country and the method is being successfully tried in some hospitals. Mothers and babies occupy the same room, the mothers gradually taking over as much care of their babies as they wish, on a flexible schedule. Fathers can visit the hospital at times more convenient to them and can handle their babies and help in their care. The plan is carefully conducted so as to prevent fatigue on the part of mothers and to insure the selection of parents who can best profit by the experience.

As we see projects like the above coming into being, we are impressed by the need to listen to the patient with respect for his experience and point of view and with recognition of cultural patterns. We have sometimes worked too hard to achieve a separation between mother and newborn baby, perhaps sensing some artificiality in this ourselves and realizing that our aim was contrary to family patterns. Now we see the validity of some of those patterns when adequate medical safeguards are added.

During the six-week postpartum period the work of the nurse is simplified if she has known the mother as an antepartum patient. She will know how the patient may be expected to react and can recognize what, for her, may be deviations from the normal. She can gauge more exactly the significance of such

behavior as the mother's unwillingness to return to her physician for postpartum examination, confusion in taking up her household duties, or difficulty in caring for the baby. The fact that care during the postpartum period is so greatly simplified by previous knowledge of the patient shows again that it is the patient's manner of meeting her problems that is primarily important, and not the problems themselves.

A mother who recently added a fourth to her family of three small children is an illustration. The kitchen of this home resembles a day nursery — a baby wherever one looks — but the mother has the strength and interest to cope with the situation, which to her does not constitute a problem. Perhaps we meet more commonly the mother whose days seem to be a turmoil of work and effort after the arrival of a second baby and who tells the nurse never to let anyone delude her into thinking that two babies are only twice as many as one.

Even when the nurse's services are accepted as essential and her visits are therefore welcome during the postpartum period, individual problems may arise which must be thought through. Why does one mother resist certain aspects of postpartum care? Is the dependence upon the nurse which another mother may now show for the first time the expected emotional lag of the postpartum patient?<sup>23</sup> Is the behavior of a third verging on the abnormal?

Certain familiar situations and reactions of patients stand out in the mind of any nurse as she considers women she has known during this period.

One task which the nurse often finds left in her hands is the need to encourage the patient to return for her postpartum examination at the close of the six-week period. So often the examination seems unimportant to the patient. She is tired of taking care of herself and going to doctors. She is free of her physical burden and is enjoying her release. She will not be endangering the baby by failing to report for examination. She "feels all right" and the possibility of difficulty seems remote. Or she may be really ignorant of the reason for an examination of this kind. Perhaps her physician has not followed the leaders of his profession in suggesting postpartum examination. Or her reason for resisting the examination during the antepartum period may

endocrine disturbance during lactation: "Mother depressed, nervous. Thinks she is not going to get well. Worries about the baby." And later, "Patient beginning to feel better. More cheerful. Goes out every day. Does not feel confused any more. Doesn't seem to think so much about her own condition."

If a postpartum patient shows persistent or unusual confusion and depression, the nurse will work even more closely than usual with the physician, realizing that these symptoms may indicate a developing psychosis. It has been suggested that the nurse has a special responsibility to be alert to symptoms of psychosis in the latter weeks of the postpartum period because the patient is then as a rule not so closely in touch with her physician as during the antepartum period or the days immediately following delivery. Furthermore, the patient's family may be slow to recognize her condition, since, as studies show, abnormal symptoms in the postpartum patient are characteristically those of depression rather than of the more spectacular excitement observable in the psychosis during pregnancy.

#### PSYCHOSES DURING THE MATERNITY CYCLE

Dr. Philip Piker, in an article published in the *American Journal of Obstetrics and Gynecology*, summarizes in an especially helpful way some of the material available on psychoses occurring during the maternity cycle.<sup>62</sup> He repeats the statement, familiar to us, that "there is no psychosis of pregnancy." Nevertheless, it can be shown that "of all females who suffer from psychoses of various sorts, almost nine per cent develop their mental disorder in connection with the reproductive experience." Since pregnancy is so frequently the precipitating factor in the breakdown of a woman who is potentially unstable, the author suggests that the interest of the obstetrician "can no longer be confined to the pelvic outlet." An instance of obstetrics practiced with this broader purpose is the work of the psychiatrist, Dr. Lloyd J. Thompson, now of the Bowman Gray School of Medicine, Wake Forest College, Winston-Salem, North Carolina. As part of a community program, he routinely interviewed all primiparae reporting to the antepartum clinic of the New Haven Hospital. Dr. Thompson found that the great majority of these

makes the patient feel that identification with the nurse is worth while.

This is one of the most difficult and thought-provoking points in the application of mental health concepts to public health nursing, and raises in some people's minds an apparent conflict between the two. On the one hand, the community holds the nurse, among others, responsible for teaching health to people. Teaching health frequently must include, for example, the attempt to convince a patient that it is advisable for him to go to a sanatorium or in other ways radically to change the course of his life. Not only is the nurse held responsible for "progress" in many such instances, but pressure, sometimes political pressure, may be brought to bear on the organization of which she is a member to "show results." On the other hand, the nurse is dealing with the complex lives of people. It is a question how far we may intrude on them. Perhaps it is possible to reconcile the two points of view when we realize that our recognition of people's complexity and the ways in which the nurse may relate to her patients and their health problems is just as literally public health nursing as the application of medical facts.

The ways we have discussed of bridging the gap in the relationship between patient and nurse are appropriate to the nurse who covers large areas and who sees her patients seldom, or for the most part in groups, as well as to the nurse who carries an urban case load. At some time in the future, rural areas will have a more adequate ratio of nurses to population so that the nurse will have more opportunity for individual work. However, all nurses, under whatever conditions they work, can ask themselves, "What do I represent to the patient?" "What does this patient or group want?" and act on the answers they find to these questions.

The development of a working relationship between nurse and patient may be a slow process, and for this reason rural nurses may have the advantage. Nothing hurries the turn of the seasons or the succession of the crops. Those who live or work in the country come to a useful realization that growth takes time. A mother seen by the nurse briefly and only once may come back to the nurse a year later. The relationship may not have stood still meanwhile. The interest which finally brought the

## THE PATIENT'S FAMILY

Up to this point discussion has centered upon the woman herself as she passes through the phases of the maternity cycle. The patient's family has been brought into the picture only to suggest some of the ways in which her relationship with her parents or with her husband affects her reaction to pregnancy, and to point out that such methods as natural childbirth and rooming-in can foster a satisfying relationship between the two parents and between both parents and the newborn child. However, it is apparent that pregnancy and the postpartum period affect all members of the family. Many nursing organizations are making a definite attempt to satisfy the interest of fathers. For example, the response of prospective fathers to classes in the health aspects of pregnancy and in infant care has been encouraging. It seems true that in the past we have identified ourselves with the prospective mother without sufficient consideration of the father, who actually may be the most helpful person in a given family.

In over a hundred antepartum situations listed by nurses in one organization as presenting special difficulties, about one-sixth were considered to be problems because of difficult family relationships apparently intensified by the pregnancy and later by the presence of the newborn baby. A number of these difficulties related to the young children in the family. For the most part the records described the children showing difficult behavior during the pregnancy of the mother and upon the arrival of the new baby as "spoiled, dependent, and unprepared for the new baby." If the nurse considers maternity work as a part of family health work, she will wish to recognize just such problems as these and to help the family solve them.

It is a common experience for the nurse to find that parents feel quite unprepared to give their small children answers to the questions they usually ask, such as why the mother looks different during her pregnancy and where the baby came from. We are familiar with the traditional explanations of buying the baby, finding the baby under a cabbage leaf, and many others which serve as a temporary escape from embarrassment, at the cost, ultimately, of some of the child's trust in the parents. A

logical opportunity for giving the child information which he requests in words or behavior exists in the everyday situations such as hathing, dressing, and the like, or when the child asks questions about what he has observed.

Not infrequently a mother asks the help of the nurse in telling her older children of her pregnancy. Such requests for help would seem to require in each case that the nurse try to think through the probable reasons for the parents' inability to handle this situation themselves. Perhaps they merely lack the vocabulary and could best help their children themselves if aided by reading or explanation. Perhaps the mother is feeling her way out of a tradition of silence regarding sex matters, but still finds herself unable to put her new principles into practice. Perhaps inability to discuss the coming baby with the children, especially the older ones, is an indication of an unsatisfactory relationship between parents and children. If she finds that certain parents are not able to talk to their children simply and easily as occasion arises, the nurse needs to make in each case the further decision whether she herself is the appropriate person to help these particular children; or whether there may not be someone else with whom they customarily discuss matters of importance to them who could be called upon for help.

During the postpartum period the children in the family, especially the youngest, have to face a difficult problem, for they must share with a newcomer their most fundamental possessions—parents and home. Preparing the child for the new baby was suggested above as a practical opportunity for meeting his interest in sex matters. Actually, preparing him to share with a new family member includes much more than this. It might be seen as a process beginning at the child's own birth, so that his security as a very necessary member of the household may be deep-rooted, as well as his feeling that at least part of the time it is fun to do things for himself. If the mother waits until the new baby is almost there and then attempts to wean the child from the bottle or to toilet-train him because she realizes she cannot cope with the physical care of two babies, the older child may be frightened and angered at the sudden demands on him. The demands may be made doubly puzzling by the fact that his mother seems in some way different. For example, a four-year-

old boy, an only child, had been allowed to spend all his time with his mother. At the time when his mother was nearing delivery, he was quite unable to play by himself and was bewildered and unhappy because his mother could not play with him. Perhaps such difficulty will show in temper tantrums or aggressive behavior toward the mother and later toward the new baby. Perhaps the child will find it easier to regress still further into infantile ways so that instead of playing the part of the older child on the arrival of the baby he will be more of a baby than ever, wanting to be fed, forgetting his toilet training, demanding to be held. This behavior is expected of the baby; why not of him?

The following are brief excerpts from records showing something of this kind apparently taking place:

Since the birth of the new baby, John insists on getting into his parents' bed at night. He must hold his father's hand in going to sleep. He stiffens out when his parents attempt to carry through anything with him. The parents believe all this happened on his week's visit to Boston during the mother's delivery of the new baby. He cried all the time there and returned in poor condition. Mother told the nurse the child was well trained, but the nurse's record shows he was a premature baby, had an inadequate diet during his early months, then was overfed; that the mother had not been interested in training the child.

Child is very jealous of the baby. Has a history of sudden weaning and toilet training shortly before the birth of the baby. Now very aggressive. Hits out. Is negativistic. Kicked and cried when the nurse wanted to weigh him.

Mary did well until the coming of the new baby. Now she talks baby-talk and shows jealousy. She bites her fingernails and toenails. She shows what seems to be attention-getting behavior. The grandmother babies her.

Jealous of new baby. Aggressive. Not getting on well with others and is expected to play like a much older child. Mother not spending much time with this child now.

Jane insists on being fed. She has regressed in this as well as in toilet training since the birth of her younger sister. Mother scolds and spansks and grandparents sympathize with the child. Child shows stubborn resistance to the things she is asked to do.

Robert has been "spoiled." He seems to get more attention than the baby. If the baby does not finish his bottle, Robert will take it from him and drink the rest.



## Chapter 2

# TEACHING HEALTH

### »» PART I ««

#### *The Relationship between Nurse and Patient*

The teaching of health may seem to be a simpler matter than it was some years ago. At least it is easier to get in touch with large numbers of people. Community organization for health has been growing stronger and there is less duplication of effort between agencies. Our system of communication, including motion pictures, radio, and television, has grown so rapidly that it is possible to bring information about health matters to large and widespread audiences.

Some of this information is essential and well presented. However, some of it, though valid enough in itself, is overemphasized for commercial reasons, and occasionally some information seems downright invalid. Furthermore, broad informative programs, however excellent they may be, often need supplementation or even rectification in order to be appropriate to individuals. Therefore it continues to be necessary that the nurse meet the patient and his family, whether or not health information is available through more impersonal channels.

When a public health nurse meets a patient for the first time, a new situation is created and a new relationship may begin between these two people, one which we hope will result in productive work. However, we realize that the situation is not completely "new." Both nurse and patient have lived a considerable number of years, each in his own way. In addition to this, almost everyone in any community has some preconceived idea of what it is the nurse can do, or wants to do. An increasing number of people realize that she has a useful knowledge of health matters and for this reason will wish to learn all that she can offer, will seek her out, and will use the information well. However, many families still think of the public health nurse primarily as a bedside nurse, to be called in an emergency. Others would like to become dependent upon the nurse in matters of

the whole idea made her "sick." Her attitude toward the mother's pregnancy seemed to the nurse a miserable beginning for the girl's own adult life, indicating as it did poorly digested information and perhaps difficult family relationships.

This chapter has emphasized some of the emotional reactions of maternity patients to pregnancy and to the delivery and post-partum periods, as these reactions affect the work of the nurse. While the patient's attitude and behavior are influenced by the fact of her maternity and by current surrounding circumstances, they depend primarily upon the patient as an individual. The patient's pregnancy and the arrival of the baby affect the other members of the family as well as the mother. Furthermore, the mother's attitude toward her pregnancy and delivery is carried over in her subsequent care of the newborn child. Here, as in her other activities, the family is the nurse's unit of work. As was suggested in the introductory chapter, the maternity work of the public health nurse can be a direct and specific contribution to the mental health of the individual and the community.

## Chapter 1

# MENTAL HYGIENE IN PUBLIC HEALTH NURSING

### »» INTRODUCTION ««

If one talked with nurses in various parts of this country eleven years ago, when the first edition of this book was written, one had the feeling they wished—and sometimes expected—that mental hygiene could offer the nursing profession a form of Ten Commandments, easily applicable to crowded days and large case loads. Our case loads still are large and our days busy, whether we work in city districts or in rural areas. However, although we may sometimes long for someone to tell us what to say or what to “do next,” as a professional group we seem to have passed the stage when we, like many others, expected mental hygiene to give us blanket definitions as to “right” and “wrong” procedure in work with people. Today there is a growing recognition that mental hygiene offers no such short cut but rather an informed, deliberate, observant method of working, a habit of stopping to think what the behavior of the patient and others may mean in relation to a situation and how the nurse herself relates to it.\* Nurses ask themselves questions such as these: What do I know that seems valid in situations of this kind and in this specific situation? How best can I put to use what I know? How can I learn more?

No easy substitute exists for the processes which lead to such increased understanding. Mental hygiene can never be a soothing contribution to professional equipment and point of view. It is too stimulating for that. One cannot escape from the constant need to weigh circumstances and behavior once one has accepted this way of working. Furthermore, it may be unsettling to find that outgrown attitudes or beliefs must be left behind as understanding of oneself and of others grows.

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\* “Behavior” is used in this book as meaning *the entire response or adjustment pattern of the individual.* “Situation” is used somewhat loosely to include the factors which exist outside the individuals involved and the internal factors as far as we know them—the personality make-up which results both from inborn tendencies and from past external factors. Their interaction in a given instance constitutes the “situation.”

cated beings whom perhaps we once enjoyed. Such artificiality on our part would be unfortunate, because the friendly affection for children which often makes a nurse a sort of Pied Piper as she walks along a city block or enters a schoolhouse is valuable to both child and nurse. Although there are controversial areas, it is reassuring and stimulating to find that materials about child growth and development are becoming more coordinated and valid and can give us a clearer insight into our work with children and their families.

We have gone a long way toward protecting the lives and health of infants and children. *America's Health*, previously quoted, shows that the mortality rate for children of preschool age was cut in half during the period from 1933 to 1945 and that the death rate of children from five to fourteen years of age was almost halved during the same period.<sup>75</sup> Progress has also been made in reducing the deaths of infants after one month of age. Yet we still have far to go. Of the children who die during their first year, two-thirds die in the first month. More infant deaths are attributable to premature birth than to any other factor, though it has been shown that specialized hospital facilities could reduce the general death rate due to this cause by about half. The nationwide, state-by-state study conducted by the American Academy of Pediatrics in cooperation with the United States Children's Bureau and the United States Public Health Service showed that children in some states receive only half as much care as do children in other states and that for the former, care is inadequate, spotty, or lacking.<sup>8</sup> Nurses who have been in the field for a long time have seen shifts in the incidence of the illnesses common to children and realize that accidents, rheumatic fever, and heart disease now head the list. Such facts as these are part of our reality picture, and help to focus public health work including the work of the public health nurse.

The family — or some substitute for it — forms the child's emotional and cultural environment and much of the nurse's work is done with parents or other members of the household rather than directly with the young child himself. The attitudes of the members of the family, and of the nurse, have a bearing on the child's reactions and behavior. Although a child is born with a certain constitution and with his own individual tendencies, an

## *Acknowledgments*

IT IS A PLEASURE and a satisfaction to acknowledge indebtedness to the nursing profession for the experiences that underlie this book. The original edition was based on an index of more than a thousand patients and situations that had been discussed by nurses with the author. The intervening years have brought continued companionship with nurses, a further opportunity to compare notes with them, and, more recently, have given the author the opportunity to continue to learn through teaching in an academic environment that encourages free and productive work. She is grateful for the organized strength of her profession as a whole and to the many nurses who, as individuals and in groups, have stimulated her, worked along with her, and on occasion have borne with her.

She also thanks her fellow psychiatric social workers and the psychologists and psychiatrists with whom she has worked and learned, and who have been interested in the work of nurses. Among the latter the author wishes to mention especially Dr. Paul V. Lemkau, Associate Professor, School of Hygiene and Public Health, The Johns Hopkins University, who has been a leader in visualizing and putting into words the role of the public health nurse in mental hygiene; and Dr. George S. Stevenson, Medical Director of The National Association for Mental Health, who has given generously of his time and his creative ability to the work for the Mental Hygiene Committee of the National Organization for Public Health Nursing since that Committee's inception.

How does one properly thank the men and women who have had vast and useful ideas, and rich clinical experience, and who on this basis have written fine books that help us? The author can only thank them by quoting or referring to many of them in the following pages.

R. G.

*Stony Creek, Connecticut*  
*April 1951*

the opposite sex. This acceptance of the inevitable is the child's first resort to an anxiety-free compromise between the claims of his own nature and those of his environment. His efforts to avoid giving offense to this factor in the environment—the father—in order to escape its threats of pain and the loss of love, give rise to the germ of an internal conscience or monitor. And about this cluster all his later acquisitions for adjustment imposed by society. By the time the boy and girl have reached the age of five or thereabouts they have had to face this, probably the most important, call for adjustment. The mastery of the so-called Oedipus complex is probably never achieved completely. Traces of hostility between sons and fathers and between daughters and mothers can be discerned among well-adjusted people."

In this excerpt Dr. Glueck has described in part the first three phases of development of the infant and young child according to the Freudian psychoanalytic school of thought, although he has not specifically named them. The usual nomenclature found in the psychoanalytic literature to describe the successive phases of child development—each term based on the most noticeable behavior of the child during that period—is as follows: the oral phase, the anal phase, the oedipal period, the latency period, puberty, and adolescence.

The nurse is helped by familiarity with the well-developed concepts that these terms represent, for, whether or not she and the professional groups with which she works accept them in their entirety, they provide her with a useful frame of reference. They give her a necessary background of information which she may apply in her work and with which she may compare the modifications of these concepts, or departures from them that emerge from the research or clinical experience of leaders in such disciplines as psychiatry, psychology, and anthropology. The nurse soon realizes that the phases of development named above are not clear-cut, that they merge imperceptibly into one another. She also understands that the child may become fixated on any of these levels of development or may return to a previous level if the growing-up process becomes too hard for him. We have seen children who apparently have been successfully weaned, but who demand the breast or bottle again after an illness or when they see an infant sibling being fed in this way. One does not refer here to the occasional demand on the part of a child that he be "habied" or to the expected "accidents" in toilet training,

but rather to the insistent demand of a child that he be cared for in ways that we had thought he had relinquished.

Dr. Irene M. Josselyn, of the Michael Reese Hospital in Chicago, describes these successive phases in her publication, *Psychosocial Development of Children*.<sup>55</sup> She writes of the expectation that a child will be able "normally" to move from one developmental phase to the next: "Maturation proceeds smoothly from one level to the next under situations meeting two conditions: adequate emotional gratification at the lower level and experiences both actual and emotional that indicate it is safe to leave one level of adjustment and explore a higher one." "Safe" here means psychologically safe from the child's point of view. An excerpt from a nurse's record illustrates this:

In the last few months John has learned to play much better with the children next door. At first he had to run home all the time to check up on whether his mother was there and he even seemed afraid the house would vanish. Now he seems to realize that his house and his mother stay the same and he only goes home occasionally to show his mother something. She even has to call him for lunch.

Dr. Josselyn's book is especially helpful to nurses not only because it shows the child's growth from the self-centeredness of the young infant to an increasing awareness of the people around him and the consequent building of relationships with them, but also because it shows this growth, to some extent, in relation to the child's physiological maturation and in relation to the demands that society makes upon him. These are the demands that he shall be "trained," that he go to school and learn to be a member of a larger, more impersonal group, that he get ready to found and support a family of his own. The demands and the resources of society constitute the cultural factors that surround and influence the individual during all of his life. Sometimes we forget how much society offers us in our awareness of how much it demands from us.

As is true of the individual, any family is like all other families in some ways, like many other families in some aspects of family life, but different from any other family that we know in a few of its attitudes and practices. All parents expect, for example, that their children ultimately will be toilet trained, and a considerable number share with their neighbors the expectation that

this will take place promptly and that the mother should work hard to bring it about. And because of her own unique combination of attitudes and experiences, a particular mother may be intensely compelled to train a baby to be "clean" when he is in infancy. We are aware that people in our society have certain common attitudes and ways of behaving. We also see that each family is different from others and that the nurse needs to study each family's way of life if she expects to work intensively on behalf of the children in the family.

The family's way of life includes not only the kind of united front that its members might present to outsiders, but especially the relationships within the family — the role assumed by each member in relation to the others. The following suggests ways in which many of us have described the father and mother roles in relation to the expected masculine and feminine pattern:

The mother gives the infant the first security of love and close relationship on which is based his future self-reliance. The father, on the other hand, can be thought of as representing the world outside the home — a mysterious world, complicated, powerful, and fascinating to the child. If the father is kindly, this power of the world outside seems benign and the child is less afraid, when the time comes, to test his independence and become a part of what lies away from home. The kindly father who is consistent in his suggestions and commands may succeed in teaching the child that it is the situation which actually is exerting authority and not the father alone. If the father has been dominating or has been obliged to carry out all the family "discipline," the child when he grows up may continue to rebel against constituted authority or may always need to be under the direction of an executive, an organization, or a political regime that expects obedience without creative contribution from the individual.

The line of demarcation between the roles of mother and father as just described may not be as clear as it once appeared to be. Fathers are becoming more interested in the physical care of babies. Many are skilled at bathing, feeding, and dressing them so that the babies, aware of the father's care as well as of the mother's, feel for him the kind of affection they give to the mother. At the same time, mothers, either from necessity or preference, may be a part of that "mysterious outside world,"



having responsibilities toward jobs as well as homes. However, though it is true that some aspects of the masculine and feminine roles may be developing along a slowly converging line, at least they have not met, as witness the conflict of the man who admires his wife's professional interests and abilities but wants the satisfaction of supporting her; and the woman who wants the independence of a job but at the same time the comforting protection of her husband.

Occasionally an actual reversal of roles takes place, a situation which needs recognition and acceptance by the nurse. In one family, for example, an injured war veteran did a good job of taking care of home and children while his wife contributed the weekly pay envelope. Both appeared happy in their occupations. The father's monthly compensation check helped to solve any conflict he may have had by giving him a feeling of earning. The mother's occasional attempt to care for the home so upset the household that she appeared glad to return to the business world, which was more comprehensible to her. In a sense this was an adjustment which worked well. However, it is difficult to see how the children in such a family could successfully establish their masculinity or femininity, psychologically, through identification with the parent of the same sex.

In the experience of the nurse some fathers do not play their classic role in a way that is helpful to the child. Any nurse can recall in this connection fathers whose presence at home means the repression of the normal activities of other members of the family, and sometimes actual fear and need for protection. For example, if the father is the introduction to the world outside and, for the daughter, her first acquaintance with grown men, the predicament of many girls in families where an old-world tradition prevails is significant; their subjugation to the father often leads to rebellion against him. An interview with a father in which the nurse suggests to him that he is giving his children a warped idea of power may be difficult to imagine. And yet an appeal to a man for the good use of his strength seems sound enough, especially when one considers that strength used to dominate is often based on some insecurity in the man himself.

The following instance serves to emphasize the point. When the mother of a family was suddenly hospitalized, the father did

not know how to care for two boys, five and six years old. It was summer and the father was at work all day. He commanded the boys to stay in the house, but they slipped away to play. The next day he chained them securely to heavy furniture, and the nurse found them so. The nurse sought the father out on his construction job, wondering what kind of individual he would prove to be. She found a man at his wit's end from worry about his wife and fear that their two boys would be injured on the street. He said, "I scare them good so that they don't get hurt." The nurse replied, "You just make them afraid of *you*; then how can you help them?"

The following example comes from a different type of home — one of considerable mutual understanding and financial ease. This father's business took him away from home for days at a time, so that he saw comparatively little of his five-year-old son, the only child in the family. This boy was timid when away from his own home. He feared crowds, elevators, busses, and did not like to play with more than one other child at a time. He preferred quiet occupations and did not know how to play boys' games. The mother herself suggested in conference that he saw too little of his father, though she connected this with his lack of play activities rather than with his fears. She explained that the father was tired when he came home from traveling and felt he should rest. This man, however, was one who could be approached directly about the boy's problem, and the mother did so. The father had thought he was meeting the boy's needs by providing for him so comfortably. When he realized that his son needed his companionship he was first surprised and then profoundly pleased. In this instance, the father's intelligent participation — his assumption of the whole father role — gradually gave the child security to venture away from his own familiar house and garden. In other words, the child became able to function as a separate individual on the basis of a closer relationship with his father.

These were examples of fairly successful departures from the role of mother or father, or of temporary misunderstanding of the role. We would not call this behavior maladjusted. Beyond this, though, we see the unsuccessful behavior of parents who, as individuals and in their relationship with each other, are un-

fulfilled and unhappy. We have seen the way in which such a parent may cling to a child, becoming the rival of the marriage partner in this, or may welcome and foster continued dependency on the part of the child in order that the parent may feel necessary to him.

In describing the influence of this primary cultural unit — the family — on the child, Dr. Frederick Allen discusses family relationships as a *balance of roles* within the family that is of paramount importance in determining whether or not the child can grow steadily toward the goal of becoming a sufficiently strong individual. In the early chapters of his book, *Psychotherapy with Children*, he discusses the significance of family roles in a way that departs somewhat from Dr. Glueck's description of the oedipal phase, previously quoted:

A broader and more positive understanding of growth follows from a functional conception of the interrelated and concurrently operating forces in mother and father and child as they live their appropriate roles together. In the failure of one or more roles, the entire balance of the family is disturbed. . . . Parents' uncertainties and emotional entanglements, focused and intensified around the child, throw out of balance the necessary functions of mother and father roles. The reactions of the child to these disturbances can distort further the family drama and lead, in some instances, to the determined, possessive drives frequently misinterpreted as incestuous in origin, but which actually may and do take on this meaning through the development of the struggle itself. . . . Ample illustration of the operation of these influences in modern family life can be drawn from the records of any child guidance clinic. We see how mothers strive to hold children as undifferentiated parts of themselves and thus fail to give the natural love and direction children need to guide them in the affirmation and achievement of their own differences. We observe how a child may struggle against the demands of growth and attempt to retain the mother as a symbol of infancy, resenting strongly the father with whom he must share the mother. These are common clinical problems. Yet these reactions of father, mother, and child cannot be studied and treated as separate phenomena since they cannot, by the nature of life, be separate. They are aspects of the drama of growth and of self-definition, not the outcome of a hypothetical incestuous attachment of the child to the mother.'

Hopefully, as the days and then the years go by, the child becomes "a person in his own right." At first he was completely dependent and able only to take from others. Gradually he could do more for himself and at the same time could learn to see and love those closest to him, and later other people who also formed

his environment. Dr. Allen calls this process one of continuing, successful *separation* of the child from those nearest to him so that he becomes increasingly more of a person himself, and at the same time is held less closely by his parents, who see him at first as almost a part of themselves. We may have thought of "separation" only as a painful experience or as withdrawal from others. The concept under discussion here shows its constructive aspect. Only relatively mature parents can gradually allow a child to become a separate person. Such parents are those who do not need to get their satisfactions from the child alone, but rather have their own strengths and their own successful roles in the family situation. Under these circumstances, Dr. Allen says, a *balance of roles* is achieved in family life rather than a stereotype of the "good" mother or father.

It has been shown that at every phase of his emotional development the child is influenced by his relation to his parents. But families usually include more than one child. Brothers and sisters enrich and complicate the growing-up process. The relative positions of children in the family group are traditionally described as those of the "older child," the "middle child," and the "youngest child," with the privileges, deprivations, and responsibilities appropriate to each. Although these children may be born of the same parents, studies show that no two children in the family can be said to have quite the same emotional environment. One child may have been born at the early peak of the parents' feeling for each other, a time, however, when there are still difficult adjustments to be made; another may have been born at a time of special financial difficulty. One child has been planned for, another has not. While the parents may love all their children, probably it is impossible for them to "feel the same" toward them owing to such factors as these. These diverse feelings unconsciously influence the way in which the parents direct the child or react to his behavior. To the child, the other children in the family bring varying relationship possibilities. Sometimes the older and the younger siblings are rivals; sometimes the older siblings, like the parents, help the young child to independence and add to his knowledge of life outside his home. Probably both these attitudes will exist. In all sibling relationships considerable ambivalence is present, the children ines-

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capably feeling some jealousy while at the same time loving one another and presenting a strong family front to outsiders. The child's relationships with his siblings, like his relationship with his parents, prepare him to live well or ill with other persons later on.

Grandparents as well as parents may be a part of the household. When this happens, not only additional persons but a third generation becomes part of the home and of the child's environment. This older generation may not really be very old chronologically, and may be active, informed, and helpful. On the other hand, grandparents may still be seeking to dominate the father or mother who, to them, may never be entirely "grown up." Deeper difficulties are observable when father or mother is uncertain which tie is stronger — the relationship with the marriage partner or with the parent. Sometimes the tie to the parent definitely is the stronger, with resulting marital difficulty. Situations of this kind were illustrated in the chapter on the maternity work of the nurse.

Grandparents may or may not accept the current information and methods that the nurse represents. We are familiar with the difficulties caused by the grandmother who values her experience in child training because she has successfully reared six children. However, we are becoming more aware that what we regard as scientific truth seems to move upward in spirals, and that at least part of the grandmother's contribution may be invaluable. If we recognize this part, instead of brushing all of it aside as outworn, we may contribute to better child care directly and also indirectly by establishing smoother family relationships. Prejudice and emotional difficulty are not confined to the generation which the grandparents represent. In any case, the presence of grandparents gives the child the experience of living with a third age group and, as he grows older, the advantage of additional points of view.

The young mother who insisted to the nurse that two babies were more than twice as many as one baby is in a sense correct. Bossard, in discussing family interaction, shows that there is a difference between the actual number of individuals in a family and the number of personal relationships between these family members:

Family life begins customarily with two members, husband and wife, and one set of personal relationships. The advent of a new member, such as a child, increases the number of persons by one, to a total of three, but the number of personal relationships by two, i.e., from one to three. The coming of another member increases the size of the group from three to four, but the number of personal relationships from three to six, i.e., by three. . . . The basic implication of this law is that every increase in the number of members of a family (or other primary group) results in more than a corresponding increase in the number of personal interrelationships, and that the larger the group becomes, the more disproportionate is the increase."

Since in our work with children we as nurses try to focus on the "whole child," we need as accurate information as possible on physiological growth and maturation, always, however, in relation to psychological maturation. Growth is measurable by weighing and measuring. Maturation includes development of the body systems and organs and their coordinated functioning.

It is helpful to the nurse to know how far the infant's senses of sight, hearing, taste, and smell are developed at birth and during the first months following birth, to know to what extent he can normally direct his movements, and to know which of his reactions will disappear because they are residuals of the adaptation to fetal life and which will develop.

"Can my baby see?" "Is it normal for him to cross his eyes?" "When will he 'notice'?" "Will he forget me if I go to the hospital for the operation?" "My baby smiled at me but his father said it was a 'colic smile.'" "My baby is extra strong; he could hold up his head when he was born." "Is my baby old enough for a rattle?" "Which hand should my baby use?" These are questions and comments taken from records or from conversations reported by nurses. They are direct questions on maturation, all of which have at least partial answers from the field of research. They are not to be brushed aside because they seem insignificant compared with inquiries about nutrition or immunization, for the answers to them help the parent to understand how the baby grows. If the mother is interested enough to question, an accurate reply will interest her further and may lay a foundation for better training of the baby.

In this connection, Dr. Bossard emphasizes the importance to the baby of "facial modes of family expression with some sound



accompaniment." He thinks that this factor may not have been sufficiently emphasized.

A good deal of the earliest communication from adult to child consists of facial expressions — smiles, grimaces, frowns, etc. — with some sound accompaniment at times. Until the child has acquired some words, communication with adults must be achieved in this way. Not only moods but ideas and commands are thus transmitted. The parent frowns and utters sharp, staccato sounds; or the mother smiles or gurgles, and food follows. These differing sights and sounds come to define behavior for the child before words are understood. Moreover, this mode of expression is retained after words are used. The child observes the facial expressions of his parents for some years and associates pleasure, anger, happiness, irritation, or annoyance with them. He learns, too, that these are often advance notices of more aggressive behavior on the part of the parent. . . . This suggests that the parent has a "facial personality" and that this is the first personality which the child comes to know.<sup>14</sup>

Growth and maturation are an evolution, one phase following another in orderly sequence though at different rates in different children. Progress toward walking is one of the most striking examples of this gradual development.

We sometimes consider that a baby is first preparing to walk when he begins to "pull himself up." But actual preparations for this pulling-up process have been taking place for many weeks. First the baby must learn to hold up his head. A newborn infant can lift his head momentarily or turn his head to free his nose for breathing, but this control is not well established until perhaps four months of age. Head posture, which involves control of the neck muscles, is the first bodily control gained by the infant. Even that develops by degrees. First he lifts his head while lying prone; then he is able to hold his head erect while being supported in a sitting position; then he lifts his head while lying on his back. He must gain control of his head posture before he can sit alone. Gradually his muscular control, which begins with head and neck, moves down his trunk. One investigator states that the baby's entire trunk must be under control to enable him to sit alone — that he "crumples from the base," so to speak, when he fails to sit up at this stage. First he can sit upright for a fleeting moment, then for a longer period, and then indefinitely. He now begins to pull himself up, but while he can sit "up" he probably cannot yet sit "down," and must learn this

separately. Rolling over is also taking place about this time and is a preparation for creeping. Now the baby begins to make some progress in one direction or another, sprawled out and perhaps using his stomach as a pivot. Usually he next scoots backward. Then he creeps. Presently he will walk when led, walk clinging to objects, and then take steps alone. However, he does not yet walk like an adult. His steps are short, wide, and uneven in timing and in length. With practice these difficulties are overcome and he can walk skillfully forward and backward; can take his attention from this new skill sufficiently to carry objects while he walks; and finally learns to run and jump. Opinions differ as to whether the infant always creeps before he walks, but it is obvious from this description that the child learns to walk by gradual stages and over a period of months. Although some circumstances may give the final stimulus, he learns nothing "overnight" although he may appear to do so.

A knowledge of the gradual and orderly maturing of the baby's nervous system and his resulting behavior is part of the nurse's equipment. A mother says, for example, "When will my baby sit up?" or, "Why doesn't my baby sit up?" "Why doesn't my baby walk?" The latter questions express anxiety based perhaps on actual lack of information about the chronological ages when such activities usually begin, or perhaps on the mother's observation of the children of friends or relatives. Recognizing the mother's anxiety, the nurse may attempt to allay it by saying that children differ in their rate of progress, that the mother will not help the baby if she "forces" him, and that he will achieve these anxiously awaited developments in good time—if the nurse thinks this is true. Achievement in terms of the baby's own progress may be more helpful and interesting to these mothers than reassurance or information as to the chronological age at which achievement may take place. For example, the nurse may point out that before the baby can sit up alone he must be able to hold up his head with ease; she can perhaps show the mother that her baby is actually beginning to hold his head erect, and so has made progress toward sitting up. This is in line with the study of maturation, which increasingly describes behavior longitudinally, in terms of developing behavior patterns, as well

as in cross section in terms of norms of development according to the age in weeks or months.

During the process of maturation illustrated by the development of the ability to walk, the child has had his first experience of learning by practice. According to Gesell, behavior growth depends chiefly upon the maturation of neural structures and very little upon practice or the environment. However, while granting that a certain degree of maturity of the neural structures must exist before functioning occurs, many neuropsychologists believe that growth of structure and its use are interdependent, each reacting upon and stimulating the other. It has been suggested that in the early stages of acquiring a skill the process of maturation may be the important factor, but that after the neural tracts are mature, or nearly so, practice may be equally if not more important. The ability of preschool children to carry plates of food and to learn in other ways to help themselves when given opportunity and instruction in nursery school illustrates the importance of practice when a child is mature enough to make use of objects in the environment.

The relationship between the stage of maturation a child has reached and his ability to acquire a skill is important to the work of the nurse. If she and the child's parents try to make him acquire bladder control too early or to speak intelligibly before he is ready to do so, he may be overwhelmed by demands he cannot meet at the moment and later, because of unhappy initial experiences, he may resist doing what he is quite capable of doing. Or he may develop too much acquiescence and passivity. Training which depends upon the child's own rate of development rather than upon external standards apparently helps him to achieve independence with as few emotional growing pains as possible.

There is certain factual or statistical knowledge about the successive steps of maturation that it is comparatively easy to acquire through books or through observation. For instance, when a mother asks at what age the baby will enjoy a rattle, we can answer quite specifically that he will probably grasp it at four months and may even, by waving his arms about, make a noise with it. In time and without instruction, he will rattle it "on purpose."

But there are certain problems, such as those connected with eating, whose relation to the maturation process is less easy to establish. Why does a formula disagree with a baby? Why does an infant cling too long to the bottle? Why does an older child refuse to eat? Some day research material may be available that will help us to answer such questions.

An example of a complicated developmental problem is the infant's difficulty in learning to eat solids. He spits out his food, or appears to, because he is not yet able to control his tongue. He has not learned to chew. Later, when he can sit up, he looks around the room and is not interested in his food, to his mother's annoyance. Presently he insists on feeding himself with a spoon, but does so poorly. He drinks from a cup, but not as an adult does. As a feeding progresses he refuses to sit still, perhaps stands up, perhaps wants to play. What is the mother to do? Should she insist on "good manners"; should she feed him in whatever position he happens to be; should she remove the food and consider the meal at an end? How much have the consistency and flavor of the food to do with the child's refusal to eat it? Should refusals be allowed? Again these are questions mothers have asked nurses. They deal, at least in part, with specific stages in the baby's maturation. If the nurse understands that this is true, she may be able to prevent later problems by relieving the mother's anxiety or irritation — attitudes which play their part in creating the child's problem behavior.

There is a relationship between the child's maturation and the development of abilities and skills, and his personality development; difficult behavior can often be dealt with more easily and with better results if it is recognized as an aspect of development and is not punished as an isolated problem.

We are all familiar with the child's determined self-assertion when he begins to sense his new abilities and to realize that he himself actually is a person. In this phase he says "no" when his mother and all the attendant circumstances suggest that he should say "yes." Perhaps he is trying to show himself as well as his mother that he exists apart from her. If he is not punished for what appears to be disobedience, the experience of most mothers is that shortly he will do as he was asked.

Apparent destructiveness or mischievousness based on curi-

osity about the make-up of objects, their appearance, the way they feel to the touch, and later the ability to use them — in turn related to increasing skill in manipulation — is another piece of developmental behavior. A nurse reports a visit in which she watched a baby's interest in a shiny tin washtub which had been given him to play with, empty, on the floor. The baby carried it about, banged it on the floor, felt of it, stood on it. Presently the mother took it away from him, filled it with water, and set it on a chair in preparation for washing the baby's grimy feet. The baby continued his examination of the basin by pulling it from the chair, thereby spilling the water. He was surprised and bewildered by the dousing and by the spanking for mischievousness which followed.

The small child who takes things apart to see what makes them go is familiar to all of us. But we do not often see parents who help him to satisfy this destructive curiosity by giving him objects of his own which he can take apart without at the same time disrupting the household.

Occasionally the provision of play material does not make the child less destructive and one realizes that his behavior cannot be explained only by curiosity or by the need to experiment. A mother consulted a nurse because her boy of five broke his toys into tiny pieces and ground his crayons to dust. The nurse referred the child to a child guidance clinic where his destructiveness was found to be only one aspect of his difficulty. He refused many foods, was subject to moods in which he rebelled against any suggestion or family plan. As the child became more at ease with the psychiatrist, it became apparent that his behavior was a form of active resentment of his mother's close supervision and anxious insistence on proper ways for a small boy to behave and proper clothes for him to wear. This anxiety in turn had aroused hostility in the child which he dared to express only indirectly by disobedience and destructiveness.

It is sometimes difficult for parents and nurse to conceive of the child's handling of his genitals as a "normal" part of his development. Yet almost every child shows this behavior. It is in line with the demonstrable sequence of development by which maturation begins with the head and neck and proceeds down the trunk. In the infant the mouth is the earliest source of pleas-

urable sensation. When he is a little older, between the ages of one and five years, the child discovers the satisfaction to be found in handling his genitals. Such behavior often calls forth a reaction of fright and reproof on the part of the parent. The threats and punishment which may follow teach the child that he is being "bad" and build up a sense of guilt about the genital organs which often carries over into adult life and makes sex relations seem something vaguely wrong even though socially acceptable. This attitude separates the sex act from love and cancels the reciprocal contribution of the two emotional experiences. It is often possible to discuss these matters with parents and to relieve their fear by letting them know that some handling of the genitals is almost universal, especially in small children. If such behavior is not emphasized by the frightened expostulations of the parents or by local irritation, if the child is secure in his family's affections and enjoys a variety of activities and interests, obsessive masturbation rarely will occur.

No one can deny that public health nurses encounter extremely difficult instances of harmful sex play and even of assault. In such instances, we try to understand the environment and to do our share in planning for the safety and re-education of the children involved. On the other hand, sex play, partly as a satisfaction of curiosity, partly as a pleasurable excitement, is more prevalent than many parents appear to realize and is at least to some extent a developmental phase. Parents in "nice" districts especially appear to have forgotten their own childhood, insisting that their own children could never have had the experience. When such activities among their children do come to light, these parents are the more upset and frightened.

If the nurse is able to see the situation objectively, she may be of assistance. Perhaps the child's curiosity can be satisfied in a more acceptable way. Perhaps the parents' concern can be relieved if the developmental aspect of this kind of incident is explained to them. For example, a four-year-old boy and girl, sun suits off, were discovered on the garden steps handling each other's genitals. Each was taken home by a mother who wept with fright. When the small girl was asked why she had behaved so, she said simply, "It felt good, mother." At this the mother spanked the child almost with cruelty. The child had told the

entire truth as far as she could understand it and after the severe punishment knew no more than before why her mother was so frightened and so angry. Back of the mother's behavior lay her own attitude toward sex matters, possibly the result of a similar incident.

Social standards, in the narrow sense of the word "social," may influence the child's ability to perform in a way that is appropriate to the level of physiological maturity he has reached. For instance, they may affect his ability to talk.

Studies have been made of the rate of speech development in children of so-called "lower-class" families as compared with children from so-called "upper-class" families. McCarthy,<sup>66</sup> whose studies were based on the child's running conversation, found that the "length of response (that is, number of syllables if the baby is too young to talk understandably, or of words if reply is comprehensible) shows marked differences from one occupational group to the other, each group maintaining its proper relative position quite consistently." The occupational groups used were: professional, managerial, clerical, skilled labor, semi-skilled labor, unskilled labor. Mental level was taken into consideration in making the study. The content of conversation and the number of words used varied greatly with the environment. The study showed that "lower-class" children were slower than "privileged" children in learning to speak and that speech was more inhibited and less spontaneous among children from homes of lower levels.

Another item revealed by McCarthy's study has special significance for the public health nurse. This is the effect of bilingualism in the home on the speech of the young children in the family. As far as length of response was concerned, the hearing of a foreign language in the home did not seem to be a handicap in the child's linguistic development, though this conclusion was given tentatively. However, it was suggested that the hearing of a foreign language may be a handicap to correct pronunciation and construction in English. When one language only was spoken in the home, the children from the English-speaking home began to talk earlier than those from homes in which other languages were spoken.

Bossard summarizes materials on the relationship of child development and bilingualism in part as follows:

Studies of the effect of bilingualism on child development indicate: (a) some effect upon mental development when verbal tests are given, but this tends to disappear as the level of intellectual attainment rises; (b) a rather general consensus that the school achievement of the bilingual child suffers, especially in the lower grades; (c) that speech defects may be more numerous; and (d) that the chief problems are personal and social adjustment. . . . A study of seventeen case histories of bilinguals suggests the nature of the problems of the bilingual as a person, arising chiefly from the fact that the "other" language identifies the child with his minority group status. The concept of linguistic identification with status seems to fit the facts best."

The child's rate of development is affected by the attitudes of those surrounding him. His family may encourage him to experiment and to progress, or may restrict him either through a desire to keep him a baby or through lack of interest in helping him to enjoy the use of his emerging abilities. It is the learning process rather than maturation itself that is primarily affected by these attitudes. For example, a child may delay walking because he has learned to enjoy being waited upon. He may delay talking or refrain from talking because brothers and sisters speak more glibly. He may be clumsy because every difficult manipulation is done for him. He may be unable to solve the problems which come up because obstacles are always removed from his path. To a limited extent, the converse is also true.

As the child matures, he slowly acquires the ability to be a "separate" person with resources of his own, able to take responsibility suitable to his age — be it one year or five years. This means that he is showing increasing ego strength. However, he can be "separate" only in so far as the relationships he has with others are satisfying and appropriate to his phase of development. And it is also true that only if he is a "separate" person in his own right can he make good and appropriate relationships with others.

Studies are being made to establish more clearly the kind of relationship the child needs at a given phase of his life in terms of the degree of "separateness" he has achieved and the activities he can undertake at each phase. That is, at what age do most



babies become "object-centered"—begin to feel that a certain individual outside themselves is very important—and how and when does this interest in a single individual expand to include other relationships? For example, Ernst Kris reminds us that the intensity of the child's need for love during his first six months of life is great, "but relatively independent of the attachment to one individual."<sup>53</sup> Then, as the child's ego grows, he is capable of centering his interest on one person and centers it strongly on a mother person. "The clinging to the mother at the end of the first and early in the second year of life is a typical manifestation of this need." One recalls in this connection a suggestion in the first chapter that hospitalization of a child of this age is undertaken reluctantly. Dr. Kris goes on to point out that "attempts [to detach the child from its mother] at a later time, when independence has been accepted and some pleasure in it derived both in the mastered dependency and in the activity which the independence permits, may facilitate the conflict solution in the child's life. The educator then *has something in the child on his side*: he cooperates with parts of the child's ego."<sup>54</sup>

According to Dr. Margaret E. Fries, "Whether the ego will be strong or weak is determined by the type of life experience it encounters. Obviously, frequent integrating experiences will help the child to build a strong ego and, conversely, repeated indiscriminate exposure to traumatic experiences will hinder ego development."<sup>41</sup> We can see that experiences not otherwise necessarily difficult for the child become so if they occur at the "wrong" phase of the sequence of phases described. Not that one can always select the experiences that come to a child; but perhaps adults could be more discriminating when an unfortunate experience occurs than is always the case.

Dr. Fries further emphasizes that the parents carry the main responsibility during the early years of the child's life and that their conscious and unconscious attitudes toward child training are therefore supremely important. Many parents are aware that this is true, and furthermore are anxious and troubled because of the extent of their responsibility. Often the nurse can diminish this anxiety by supporting and strengthening the parents. We are greatly helped in doing so by the recently published materials of Erik H. Erikson of the San Francisco Psychoanalytic Insti-

tute.<sup>35a,b</sup> Nurses who attended the Mid-Century White House Conference on Children and Youth in December, 1950, or who have studied reports of the Conference, recognize how much he has contributed in his clear discussion of ego development, primarily in what he calls the "eight stages of man."

## »» PART II ««

### *Familiar Training Situations*

Eating, toilet training, play activities, and with these the child's management of himself in relation to others are primary matters in the nurse's work with infants and small children, and in large part make up the child's waking day. The child's demands and the ways in which he makes them, the ways in which his parents meet his demands, and the expectations which his parents have of him and for him interweave day after day and become the fabric of relationships between child and parents. The activities of others in the household, especially other children, are important to the child not only in their immediate relation to him but also as part of the general surroundings which influence him little by little. He reflects his family's general pattern of life and their growing or decreasing satisfactions as a family.

#### FEEDING OF INFANTS AND CHILDREN

The kind of routine that a family observes in caring for an infant, or their lack of routine, is a matter of concern to the nurse. In the early practice of public health nursing, lack of any schedule of infant care which seemed worthy of the name to the nurse may have presented more of a problem than an overstrict regime. Later, as the scope of our work widened to include parents with less limited resources, we worked with many families where a meticulous schedule of infant care (including precise hours for feeding and early toilet training) was a matter of pride. This conformed with the medical recommendations then current for infant schedules and also appealed to the nurse's sense of order. There seemed to be considerable logical basis for

this method of child care. If infants' stomachs empty in a measurable and predictable number of hours, regularity of elimination and of sleep would seem to depend on regularity of feeding. Many pediatricians and psychiatrists strongly advised strict regularity of schedule as a way of developing security in the child. It was also thought that learning to wait for food until the appointed hour was good for the baby in that it prepared him for inevitable adult frustrations. This assumption has now been completely rejected in favor of the concept that the baby gains security and that his energy is conserved if his needs are satisfied as completely and quickly as possible; that he is too young to make constructive use of restrictions; and that withholding satisfaction perhaps contains unrealized elements of punishment.

Two main objections to the "regular routine" emerged. First, it was recognized that infants differ from one another even in rate of digestion, and that each infant arrives gradually at the kind of schedule that benefits him most. Second, it became clear that advocates of the regular routine often went to extremes in establishing and maintaining such a schedule, and that this insistence might well grow out of a compulsive need for order and regularity on the part of adults in the family or perhaps on the part of the nurse.

The need for a rigid schedule was often characteristic of the family pattern as a whole. If the nurse was an extremist in this respect and was successful in passing on her conviction to the mother, she sometimes passed on her anxiety as well. And if the mother was unable to carry out the routine, or did not want to do so, her failure may sometimes have caused her further anxiety so that any possible benefits to the child from her easygoing ways of living were also lost. Many nurses and many of the families with whom they work seem to have learned a useful flexibility of regime during the last war. During that period, when several members of a household might be working on different shifts, when in many instances families moved in together, when, because of absence of the men of the family, chores and activities had to be reassigned, we all learned that there are many different ways of managing a household. Some years ago, on finding that a mother slept late in the morning, some of us

would have been disturbed, as a certain nurse was, despite the fact that the baby seemed to adjust to this. Later she found that the father's working hours were unusual, bringing him home after midnight. The mother had planned her day so that she and her husband might have some time together. Now a nurse informs herself about the family situation before she becomes perturbed over what seems to be a poor way of managing a household. Furthermore, it is not easy to assess a family's way of life. That the attitudes of the parents and not the regime itself are of paramount importance is proved to us many times by our observation that children of real beauty, with gentle manners and even dispositions, grow up in homes in which the assets may be difficult to find.

There are obvious hazards from which members of a household should protect children. However, the fact that the attitudes of parents determine the usefulness of a regimen or of methods of child care is clear. An illustration of this was brought to a group discussion recently by two nurses in the group, each of whom had been visiting a home in which the mother made use of a patented bottle-propping device for feeding her baby. One mother used this for all feedings. Much of her behavior toward the baby seemed to the nurse to show rejection of him and impatience with the details of his care. This mother would have had time to hold the baby while she fed him. The second mother had young children of school age in addition to a baby who was taking bottle feedings. She customarily held the baby when she fed him but used a bottle-propper for the morning feeding which, according to the baby's desire, came at just the time when she was trying to get the older children off to school. In discussion the group agreed that it was not the use of the device that warranted attention, but rather the attitude and purpose of the mother in using it.

Perhaps the majority of us are now working with physicians who recommend a suggested, provisional feeding schedule, which mother and baby adapt to the baby's needs and which ultimately settles down into a more established schedule as the baby himself settles down. Thus the fear that mothers would lose the advantages of an expected routine of feeding, to which

they could adapt housework and other activities, has largely been dissipated.

The following quotation from a discussion of the prevention of feeding problems in *The Psychological Aspects of Pediatric Practice* by Benjamin Spock and Mahel Huschka not only suggests in its final sentence an explanation of parental attitudes toward the flexible type of schedule, but remains one of the most practical, sanely written paragraphs on the subject that has been found in the course of considerable reading. It was written for physicians. It has to do with feeding only, but might be applied more generally to the infant's whole schedule:

Prophylaxis can begin before the mother begins taking care of her first baby. The physician can explain the importance above all else of the baby's deciding at each feeding how much or how little it wants, so long as its digestion is good. He should emphasize the passivity of the mother's role. He should present the feeding schedule as something to which the baby will eventually adjust, and the sooner the better, but give the mother permission to shorten the interval when the baby gets crying hard from hunger early. (Usually the baby will compensate with a longer sleep afterwards. If not, the formula may need to be increased or the interval decreased regularly.) If the baby is to be on a bottle, he can give the formula not as law, but as his guess as to what will satisfy it. He can prepare the mother in advance for variations in amount at different bottle feedings by showing how widely the amounts derived from the breast vary. He can encourage her to consult him as soon as the baby begins to be dissatisfied. When the physician has made these points and ended by saying that his and the mother's job is only to satisfy in every reasonable way the child's legitimate desires and never to interfere with it unnecessarily, he will often be greeted by a joyful sigh of relief. At least part of the mother's inherent anxiety and the apprehensiveness acquired from what she has read and heard about strictness, training, regularity and letting the baby cry, will thus be drained off at the start of her most difficult period."

Dr. Ruth Brickner, in relating maturation to training, says that health education for parents is of two kinds: instruction in the essential medical requirements for child health, based on the best available medical authority (and, it could be added, on studies of child development); and instruction in methods of child training relative to eating, sleeping, elimination, and play, which the mother must carry out herself. She speaks of the impossibility of applying "rules" to this second part of child training and of the bewilderment of parents who try to do so. The fol-

lowing is her summarizing paragraph on the "rhythm of growth":

Historically it is easy to see how insistence on "law enforcement" in habit regulation has come about. Before child health became a science, it was left pretty much in the hands of fate. The immediate improvements brought about by scientific care were so spectacular that the almost inevitable result was a distrust of everything else. . . . But science itself now points to the child's innate rhythm of growth as perhaps the most powerful single factor in his development. We are now beginning to realize that regulation of bladder and bowel training, management of food routines, of play and social life, should all have as their touchstone each child's inherent readiness for these new demands. This does not mean a return to the old fatalistic attitude. What seems to have happened is that our knowledge has grown in a sort of spiral which now brings us, with a more scientific appreciation of both its limitations and potentialities, to a renewed faith in the maturing process of life itself."

From observation of the nurse's work with newborn infants and their parents, one becomes convinced of her helpfulness in moderating the early anxiety of parents over the infant's feeding. No actual feeding difficulty may exist. Yet the parents watch the baby anxiously, alert for signs of trouble. In home after home the nurse bathes the infant, then supervises his feeding period. She observes him as he sucks, encouraging him, perhaps commenting amusedly on his initial hunger. She shows the mother how to help him take the breast or bottle. To the nurse, the baby is not an overfragile, alarming object. She handles him with an ease which the mother watches and gradually imitates. On her record of the visit go the information that the baby takes food well, and something of his individual manner of doing so. Hardly any part of the nurse's function with mothers and children is more fundamental than the relief from anxiety which her mere presence, her handling of the baby, her assurance that she will return, appear to bring, as well as her instruction and demonstration.

Some babies do not nurse well, even when the mother's nursing position or her possible clumsiness have been bettered. Possibly the mother's nipples are flat or inverted, or cracked because of lack of antepartum care. It may be that the infant himself is weak or has special difficulty in coordinating. He may be so premature that feedings cannot be given in the usual manner.

Anxiety on the part of the parents then becomes more acute, and more specialized skill on the part of the nurse is required in carrying out medical instructions that assist the baby to get his food.

One aspect of parental anxiety over infant feeding is sometimes more easily recognized by the nurse in retrospect than at the time when the situation confronts her. The following is an instance of such a situation:

John, the first baby in the family, was born in November. The family became known to the nurse in December. At that time the baby was not nursing well, although the cause of the difficulty was not at first apparent. The nurse observed one of the feedings and saw that the mother was exceedingly tense throughout the nursing period. She held herself stiffly and did not make the baby comfortable. She told the nurse that, for some reason, nursing the baby made her "nervous"; she could hardly sit still while he nursed. She felt like pushing him away and wringing her hands. Her "nervousness" increased when he refused the nipple and, as sometimes happened, cried during the nursing period. The nurse had not been confronted with such a situation previously. To her it seemed a simple matter to nurse a baby. She advised the mother to try to relax. The mother said she would attempt to do so. However, the feeding problem persisted, was carried over into the weaning period, and later showed itself in food fads. The family then moved away and the record was closed. Later, however, they returned to the same neighborhood and the same nurse saw the mother and child in child health conference. Consulting the old record before seeing the family again, she was amazed at what she found—and at what she had missed previously. The mother's antepartum record was especially revealing. This pregnancy had been in its second month at the time the parents were married. Throughout the pregnancy the mother had felt ill, although the antepartum clinic had been able to locate no pathology. During her pregnancy the mother had had to adapt not only to the fact that she was about to have a baby, but to marriage and to house-keeping, neither of which would she have undertaken except for the baby. Although her husband said he was glad to be married and tried to help her, she was tense and apprehensive. Delivery

was exceptionally difficult, with repair necessary. The mother said during her pregnancy and in her early postpartum period that she did not expect to have any milk for her baby — she was “not the type” who had milk. With this information in hand, the nurse wondered how she could have “preached” self-control, and so widened the gap between herself and her patient. She had had the opportunity to recognize that the mother’s tension was a probable carry-over from her attitude as an antepartum patient; she could have shown the mother that her difficulty was understandable, and, if this sharing of the mother’s anxiety did not improve the situation, she could have informed the physician of the mother’s symptoms, with the idea that other methods of feeding the baby might be advisable. It is interesting that this mother did not make the simple shift from breast feeding to bottle feeding herself without medical advice, as many mothers do, perhaps because her feeling of guilt about the baby’s illegitimate conception was so strong.

Many nurses are aware that babies sense muscle tension on the part of those who care for them and that they react in turn with fear and tension. Muscle tension may be due to the mother’s fear of handling the baby. However, it is often due to deeper difficulties such as that instanced here. In her article on inter-related factors in development, Dr. Fries includes a photograph, now famous, with the caption, “Typical Position of Mother’s Hand Showing Her Tension.”<sup>11</sup>

The introduction of semi-solids and solids is a special feeding problem on which concerned parents seek help from the nurse. Sometimes the child presents only “normal difficulties.” Many mothers complain that the baby “spits out” his first solid feeding. Gesell describes a developmental factor of importance here. In the Gesell and Ilg study we read:

Some infants are *neuromuscularly ready as early as 12 weeks of age* [for solids], but in general it is advisable to defer solids until about the age of 16 weeks and to introduce them cautiously by degrees. Even the 16 weeks old infant may still show a strong tendency to protrude the tongue and to close the lips at the wrong time when solids are presented. As a result the food is apparently spit out. This, however, is not a true rejection or intolerance. . . . But the mother is anxious to carry out the doctor’s orders. So she becomes tense and over-persistent. This does not make for pleasant associations with solids. As a matter of fact, there is no occasion for



anxiety; the difficulties are largely of our own making. If the feeding is not pressed too strenuously, or is deferred a week or two, the infant accepts the solids agreeably and without motor difficulties . . . certain nerve fibres and nerve connections which control the mouth musculature have had time to mature and have brought the child to the level of readiness."

We are accustomed to the generally accepted theory that babies should be conditioned to solids by degrees, beginning with a taste of warmed, strained soup, cereal, or vegetable, graduating to purée of vegetables and soft cereal, and finally taking mashed foods. In this way his new feeding is at first sufficiently like milk in consistency and temperature to avoid startling the baby disagreeably, though it differs from milk in taste and color.

Illustrating the emotional difficulties which may occur during this period, a nurse describes a recurrent memory picture which baunts her unpleasantly. A mother living in the small town where the nurse was employed asked help in giving her baby the solids which had been ordered by the physician and which the baby was old enough to enjoy. The mother described mealtime as a pitched battle in which the baby won. She had tried introducing the solids at each of the various feeding times during the day and had tried giving them previous to and following the bottle. The mother was distressed over the situation and dreaded the baby's mealtimes. The nurse observed a feeding and was impressed with the mother's anxiety and her evident expectation that the baby would not eat, and with the baby's definite refusal of the food. Her suggestion was, she says, that the mother leave the room while she herself fed the baby. She did feed the baby, with no difficulty whatever. She says, however, that she will never forget the mother's face as she left the room, a failure with her own baby; nor her even more discouraged expression when she returned to find that the nurse — a stranger — had fed the child when she herself was unable to do so. She wishes that she had known enough at the time to bolster up the mother's confidence in her ability to take care of her baby, instead of intensifying her failure by getting a meal of solid food into the child. If the mother had been strengthened and less attention had been put on mealtime, the baby, a healthy child, probably would have eventually welcomed her meals, and her mother would have been helped to feel capable of meeting other situations as they arose in training.

If we can help the mother to know in advance some of the normal physiological variations which are part of growth and maturation, and the ways in which these may affect the child's intake and the training period, we shall have been very useful to her. Dr. Aldrich, Dr. Lemkau, Dr. Spock, and others stress this way of working with parents, which presupposes knowledge on the part of the physician or nurse of the child's developmental phases. For example, as the child's rate of growth slows during the second year, his appetite diminishes in proportion. Of this Dr. Spock says:

... children around a year or a year and a half distress their mothers by abruptly turning against foods which they previously liked. The casualties are most often vegetables, cereal, and milk. Mothers are not prepared for this either by conventional health education, which implies that every child should take a conventional balance of food elements at each meal, nor by past experience with their children. Few mothers can resist the impulse to urge and force, and few children fail to respond by greater balkiness. But if the mothers are warned ahead of time of the likelihood of appetite changes, of the naturalness of appetite changes, and are urged to let their children feed themselves early, a majority of them (not all, by any means) can get past this crisis without harm. They and their children are then in a better position to weather the stresses of the second year.<sup>22</sup>

Weaning the baby from breast or bottle is another phase of infant feeding in which it is the nurse's responsibility to help. In its broadest sense, weaning includes all the successive steps in growing up. That is, a baby who walks has weaned himself from creeping; a child who has bladder control has weaned himself from incontinence. Here, however, weaning means specifically the baby's ability to relinquish breast or bottle in favor of the more adult — if less comforting — method of drinking from a cup. If, as is generally accepted, the baby's early experience of being fed, whether by breast or bottle, has values for him in addition to satisfying his hunger, it does not seem difficult to accept the corollary that he may feel weaning to be a deprivation. Weaning need not be a difficult experience, yet the baby often feels he is losing his mother in the very real sense of being separated from her care.

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anxiety; the difficulties are largely of our own making. If the feeding is not pressed too strenuously, or is deferred a week or two, the infant accepts the solids agreeably and without motor difficulties . . . certain nerve fibres and nerve connections which control the mouth musculature have had time to mature and have brought the child to the level of readiness."

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bottle feedings. The following quotation from the article by Dr. Spock and Dr. Huschka previously cited is clarifying:

As to the time when weaning is to be started, no hard and fast rule can be laid down because of the wide discrepancy in the rate of physical and emotional development of infants. By and large, however, weaning can be started for the average child in the last quarter of the first year though some babies may be ready for it earlier; many will need to wait until later. The precocious child or the child who has been free from feeding difficulties and emotional problems and who has enjoyed excellent health may very well be capable of beginning to give up nursing at an earlier age, possibly to be completely off the breast in his tenth month. On the other hand, the child who is generally slow in development or who has been a bad feeder or has been handicapped by illness, the unhappy baby or the unwanted child who has failed to receive the average amount of maternal love, should be allowed more time for, feeling already cheated, he will be decidedly loath to give up what emotional satisfaction he has for new ones which he does not know. Prematurely forcing the issue will only add to his problems by making him feel still more cut off from that which he loves."

That nurses recognize weaning to be a difficult process for the baby is shown by notes in their records, for example, a nurse's suggestion that the mother should take care to give her baby as much of her time and attention during and after weaning as she did when twenty minutes of her exclusive attention were his every few hours. An hour's playtime, for example, which housework or household emergencies are not allowed to cancel, seems to work well. With gradual weaning in mind, the nurse can suggest to the mother that it is comparatively easy for the child, as soon as he can drink from a cup, to accept one cup feeding. In the same way he learns to take some foods from a spoon. And gradually, before the time comes to relinquish breast or bottle entirely, cup or spoon means food to him, not deprivation.

Many of the sudden weanings take place at about the time when another baby is due to join the household. An instance of the child's reaction to the coincidence of the loss of the comforting bottle and the appearance of an apparent rival was given in the previous chapter to illustrate the regression of an older child after the arrival of the new baby. This double threat may be further compounded if the mother, suddenly aware that the care of two infants will be beyond her time and strength, attempts not only to wean the baby from the bottle but to teach

him bladder control in the few weeks remaining before the arrival of the new infant. He is bewildered by the sudden drastic demands upon him. Furthermore, he may be quite unable to meet them since developmental data show that a baby is probably capable of developing *only one new ability* at a time even if he is neurologically ready for several, and that other skills which he has begun to develop may even fall into abeyance while he attacks a new skill.

On rare occasions the nurse has contributed to this sudden weaning by taking, or appearing to take, the child's bottle away with her in her bag. Sometimes she has stood by or assisted while the mother broke the bottle before the child's eyes and explained that the bottle was now gone. We realize that such procedures are disastrous for the reason that a baby so treated has rarely achieved any appropriately mature substitute for his bottle, and is simply left stranded.

A record describes a more understanding attempt on the part of the nurse to assist in a postponed, difficult weaning. She suggested to a three-year-old girl who insisted upon her bottle at nap and bedtime that she give her bottle to the baby upstairs, asking if she would like to do so. The child assented, went upstairs with the nurse during the latter's visit, and gave her bottle to the baby. The nurse made her next visit with considerable apprehension, wondering whether the child had regained her bottle or was perhaps resentful of the privileges of the baby upstairs. This child, however, had needed just one more push in the direction of more mature behavior. She spoke to the nurse with pride about her gift to the baby and her own grown-up status.

In many households, however, breaking the bottle as a means of weaning is not an outgrown idea. Concetta, also three years old, insisted on a bottle at nap and bedtime. In a number of other respects she had apparently progressed well. She fed herself, cared for own daytime toilet needs, and was learning to dress herself. However, to anyone who observed her habits of finishing her baby brother's bottle when opportunity afforded and of climbing into the baby carriage when he did not occupy it, her clinging to the bottle would seem to have deeper roots than did the behavior of the child described in the previous para-

graph. The grandmother decided one day to end the business of the bottle and so smashed it on the floor before Concetta. The child cried despairingly and presently reverted to other immature habits — wetting her clothes and refusing to feed herself.

Although the gradual, long-time method of weaning is sound, parents may not be interested in it. In a large number of instances it is not the child who combats weaning as much as the mother. She has an emotional need to "keep the child a baby." She delights in nurturing him herself and persists in spoon-feeding him even when he is as old as four years, saying that he would not eat otherwise. Mothers may refuse to permit a baby to attempt feeding himself when his desire to do so first appears on the ground that he spills his food. Perhaps these mothers, too, wish to keep their active role in feeding the child. The mother herself may realize that her behavior is at variance with commonly accepted child training methods. She may tell the nurse that she knows her advice to let the child feed himself and to give him less attention during meals is sound, that the doctor has repeatedly told her the same thing, but that she still cannot bring herself to do it. Our very persistence in advising discontinuance of the bottle or of spoon-feeding may add to the mother's difficulty. For example, one mother took her two-year-old's bottle with him in his carriage but concealed it in a stocking because she was afraid she would meet the nurse. Other mothers insist that the bottle is no longer being given to the child when the nurse knows it is. Such examples emphasize the futility of mere persistence on the part of the nurse as opposed to the possible success that can come from understanding the patient's behavior and adapting one's approach accordingly.

Because of our feeling that it is natural and right for a mother to love and want her child — at least most of the time — it may be difficult for us to accept the idea that oversolicitousness is sometimes founded on the mother's rejection of the child. The mother, by being overmaternal, may be trying to make the child and herself feel she is fond of him and to conceal the fact that she actually does not want him and the burden of his care. This basis for her oversolicitous care may be entirely unconscious on her part. It is obvious that this is extraordinarily baffling to the nurse. Even if she has an inkling of the true state

of affairs, she cannot mention it to the mother since her remarks would only meet with a denial that would intensify the difficulty.

One nurse, who felt that the mother's unconscious rejection of the child explained in part why she fed him by force, stopped urging her to let him feed himself because she realized that her approach was only making her more hostile and unhappy. The mother presently sought her out at child health conference, apparently because she needed to feel that she was doing everything possible for the child. Instead of urging the mother to allow the child more independence, the nurse remarked that the mother was indeed having a great deal of trouble in bringing up Sebastian. This was a new approach, and the mother looked surprised. After a silence she said, looking defiantly at the nurse, "You're right, he gives me trouble. Some of the time I don't even like him." The nurse replied, "That isn't so strange; many mothers feel that way." The mother burst into tears and said she had thought she was the only unnatural mother except the people one read about in the papers.

The temptation is to leave the story here, since the point it illustrates has been made. However, real trouble on the part of this mother had been uncovered with the help of the nurse, and it would be unfair and irritating to the reader to leave the situation dangling. The actual ending may be just as irritating to those for whom like resources are not available, for in this case it was possible to refer the mother and youngster, on the request of the mother, to a child guidance clinic with whose study of the family the nurse then cooperated.

When a deep-rooted emotional difficulty such as this comes to light, what are those of us to do who have not access to such resources? One procedure at any rate is always open to us — and though it may seem negative in that it carries a suggestion of what not to do, it is positive in its effect upon the situation. Recognizing that the mother's oversolicitousness is a symptom of her conflict, we can re-examine our professional purposes and stop adding to her difficulty by urging her to give the child less attention. Nor, it seems, should this be interpreted as a suggestion for "absent treatment." The mother needs the nurse — or someone — badly. However, she needs a nurse who can understand and accept her real problem, of which the child's refusal



to eat and her insistence on feeding him may be symptoms. How much further than this the nurse will feel justified in going — whether she should encourage the mother to talk freely as she becomes more at ease under the nurse's uncritical attitude and whether she should make any attempt to explain — depends, one would think, on the nurse's own training in working with such problems and on the help which her own organization and other community resources can give her.

It is not intended, in discussing maternal rejection at such length, to emphasize this to the exclusion of other reasons why the mother nurses or feeds her child too long. Oversolicitousness may be just what it seems — a recognizable carry-over of a much wanted pregnancy, as illustrated in the maternity chapter.

Again, mothers who find it comforting to believe that they are victims of circumstances and misfortune may unconsciously exploit the domestic complication of food fads and difficult feeding in order to justify their feeling of martyrdom. We also meet many mothers to whom, as previously suggested, routine, including routine of meals and perfect behavior at mealtime, is a necessity. Food is often a cultural symbol. This may partly explain why children in Jewish families sometimes have feeding difficulties that seem to be based on the attitude of the mother.

With the permission of Dorothy E. Hall, mental hygiene consultant at the Infant Welfare Society of Chicago, the following excerpts are taken from material presented by her at a meeting of the American Orthopsychiatric Association. She cites the impression of the nurses with whom she works that certain behavior is so typical of one or another nationality group that the nurses often "gauged the seriousness of a behavior symptom not only in relation to the individual child but in relation to the cultural group to which he belonged."

For instance, in one district where there is a large Jewish registration, variations from the usual development of health habits related to food occur so consistently that they are considered the usual rather than the unusual. Weaning is started here as in any other district. . . . In spite of instruction given these mothers as to gradual weaning, the impression held by nurses who have worked in this district is that the Jewish child remains an infant, as far as taking food is concerned, much later than other children. Situations which in another district would be referred by the nurse for psychiatric advice are considered typical for this group.

An example of this is a child thirty months old still taking food from a bottle, refusing to hold cup or spoon and regurgitating all foods unless strained.

When staff nurses were given a list of problems pertaining to eating, sleeping and elimination and asked which ones they would expect to find prevalent in each of the following groups—Jewish, Polish, and Negro—100 per cent expected to find the Jewish child over two still being fed; 83 per cent expected to find most frequently in Jewish children the five problems concerning food—fed, refuses food, forced, vomits, takes bottle. . . . To check the accuracy of these impressions, the records of 50 Jewish, 50 Polish and 50 Negro children between two and five were used. These are children from families with low incomes, but otherwise unselected. A study of behavior findings related to health habits as charted on these records bore out the staff impressions. . . . This scoring left only 7 Jewish children who were without any difficulty in establishing satisfactory food habits. There were 27 Polish and 35 Negro [children who did not show feeding difficulties].

Other behavior items checked on these same children indicated that difficulties other than those related to food did not in general occur more frequently in the Jewish than in the other groups.

Miss Hall concludes that this material reinforces the staff impression that the taking of food must have a significance in the Jewish culture which it lacks in that of the Poles and the Negroes, creating so much concern that Jewish mothers may be unable to acquire a different attitude toward it. She states:

One wonders whether this emotional tone regarding food can be traced to a culture in which dietary laws have had greater significance in religion than in hygiene; a culture in which regulations concerning food are not primarily for the sake of good nutrition but are symbolic of the separateness of a people and represent a discipline of all appetites. Much of the ceremony on special occasions employs food in symbolic form. . . . The Jewish woman's participation in the religious ceremony has been largely in relation to dietary laws. . . . While many of the younger mothers do not adhere to the old practices, their attitude to the partaking of food must still be invested with emotional values which make it impossible for them to be satisfied with the amount the child will eat naturally. These are the mothers who bring well children, showing excellent gains, to the doctor and insist that the child does not eat. . . .

From other sources also one gains the impression that to many Jewish mothers the nurture of their children, particularly of their first-born son, has a symbolic value highly charged with emotion.

The material pertaining to this particular group has been used as an illustration of certain attitudes underlying feeding problems because it shows the futility of an argumentative, insistent approach on the part of the nurse, which only serves to widen the gap between nurse and mother and does not lead to an identification of interests.

The preschool child who insists on attention at mealtimes is another familiar problem to nurse and parents. He refuses to eat, perhaps demands to be fed, has many food fads. In many instances, as has been seen, the mother has unwittingly taught him to behave in this way because of her oversolicitousness. Or his food fads may merely be imitation of other members of the family. Then, too, it is natural for the child to want attention. Perhaps he is not receiving it in more legitimate ways. Confronted with this situation, the nurse may suggest that the parents give less attention to the child's trying behavior during meals. Here we sometimes stop, however, not realizing that we have gone only halfway. While it may be true that he should have less attention at mealtime, in general, he needs *more* attention, and it may be possible for nurse and parents to plan times and ways to give it to him constructively.

An only child, a five-year-old boy, made family meals dreadful events because of his refusal to eat unless repeatedly urged. The mother had tried to make his food attractive and had used many devices without success. The father, a young policeman, was disturbed about the difficulty, but could think of no better way of helping than to tell the child to eat. The nurse noticed that this father, who had a young man's active interest in sports and games, still considered his son a baby and never thought of teaching him to throw a ball or of capitalizing on his own occupation in order to enlarge his son's interests. He was surprised when the nurse suggested that he might be able to improve the situation at meals if he gave the child more attention, particularly the kind of attention that he alone could offer. No deep-seated maternal difficulty or emotional problem on the part of the child proved to be at work in this instance. The father's companionship, the interest of the games the father and child played together, perhaps the effect of vigorous outdoor activity, gradually satisfied and stimulated the child till he no longer

needed the attention he got by fussing over his food. Advice to refrain from paying attention to the child at meals would have met only half the problem. As is suggested later, this same fallacy underlies the advice that *cauresis* or temper tantrums should be "ignored," unless at the same time an attempt is made to strengthen the positive side of the situation.

A rigid insistence that the child must eat or must eat certain foods has perhaps concealed an unconscious wish to punish him. Time was when his professed dislike of certain foods met a bleak insistence that he eat them since eventually he must learn to like most foods. Nursery schools have taught more kindly ways of reaching somewhat the same end. They suggest small servings of disliked foods, a reminder to the child that he has food on his plate, sometimes a guiding hand on the fork. At the same time, the essential foods which the child does like should be stressed and given him gladly and he should be studied to learn which of the three meals finds him at the peak of his appetite.

The growing maturity of the child, which has been stressed as a basis for determining the time and method of weaning and of acquiring other feeding habits, also relates to the advisability of "stars" and like devices as rewards for meals well taken and similar successes. Increasingly, it has been the experience of those who attempt to interest the child in charts on which he pastes his own star as a reward that this device is stimulating to him only temporarily. Progress then is at a standstill, the child having built up no satisfaction in meals as customary, pleasant events of the day in which he is learning to take an active part by feeding himself.

In the two following illustrations from nursing records, a mother who needed help with the problem of feeding her child but who, at least temporarily, could not accept direct health teaching, is contrasted with a mother who needed similar help but was able to put the advice of the nurse to work because she was comparatively free from emotional difficulties.

An oversolicitous mother seemed unwilling to let her child try to feed herself. When the nurse suggested it, the mother made an attempt and reported to the nurse that she had been successful. However, the nurse noted that although some prog-

ress had been made the mother continued to feed the child most of the time. After the arrival of the next child, the nurse's record reveals her discouraged awareness of difficulty. "Mother oversolicitous about this baby's feeding. Same thing happening all over again."

The contrasting example, like the first, shows a mother who was eager to do everything possible for her baby. She made the mistake of overstressing the importance of his mealtimes with the result that he demanded attention then and wished to be fed. This mother welcomed discussion of the probable causes of the child's behavior, and the difficulty was cleared up. A further indication of the mother's objectivity is the fact that when the second baby came along she did not repeat her mistake, but remarked that she understood better now how to care for a child — although the second baby was apparently as well loved and as worth "spoiling" as the first child.

These suggestions about the public health nurse's work with the feeding of children imply that her responsibility goes beyond teaching the nutritional value of foods and includes an understanding of the emotional and cultural aspects of the feeding situation for both the child and his parents. Feeding the newborn, introducing solids, and weaning may be anxious experiences for parents. The nurse who can relieve some of this anxiety and who can broaden the interested parents' understanding of the factors involved aids the child as well as the parents, since satisfactory early feeding experiences help to set the stage for later, more diversified experiences.

#### TOILET TRAINING

The child's toilet training is a second major training situation in which mothers request help from the nurse. The "when" of attempting to teach bowel and bladder control has always been a problem. Of all the things that parents must teach and small children must learn, toilet training may be most fraught with difficulties due to adult attitudes, influenced by social values. It was at one time a matter of professional pride for the private duty nurse who specialized in infant care to be able to say that she had "trained" the baby within the first few weeks of life so that when she left the home the mother had no need to wash

soiled diapers. Many mothers still feel themselves to be in a rivalry situation with neighbors in the matter of early and complete toilet training. On the other hand, health education has made progress in this respect and one sees some of the same relaxation with regard to impossible goals for early toilet training that characterizes current schedules for feeding the baby.

When compulsiveness about toilet training exists, it seems to be based upon attitudes of which the adult is unconscious. The child is being trained for "cleanliness," and cleanliness may seem to the nurse or mother one of the most important factors in life, linked perhaps with the kind of training which she herself received. Dirt may have an unrealized special meaning, tied up with excretions. It is interesting that several psychoanalytic writers have discussed toilet training in the sense of "cleanliness." Cleanliness need have no such specialized meaning; properly, it implies merely clean skin all over the body, clean scalp and teeth, clean clothes and surroundings, all within reasonable bounds and appropriate to the moment. Mary Chadwick, in her book, *Nursing Psychological Patients* points out that the excretory functions seem to be tied up unconsciously not only with cleanliness but also with action—with "doing" and with such words as "husiness."<sup>28</sup> Also, the symptoms of many actual neuroses involve the intestinal tract and functions and thus reflect unresolved difficulty during the anal or training period. The baby may acquire all these associations with toilet training because of the attitudes of the adults who care for him. The intensity resulting from these attitudes is shown not only in the need to start toilet training early, but in methods of training. The mother of twin girls, three years old, said to the nurse, "Those children will be dry at night if I do nothing but punish them. I have always had a clean home and I intend to keep it so." The children became so upset that they returned to daytime wetting, too.

However, we sometimes make insufficient allowance for the nuisance value of the child's wetting and soiling. Any mother, no matter how well she understands the maturation process, must become very weary of diapers, puddles on the floor, and wet beds long before the child has reliable bladder control. The known exception to this may be the mother of a large, underprivileged family to whom a child who is always wet may be the

least of her troubles. If the child is not successful in learning bladder control, the mother's work is complicated, often for years, by the daily necessity of taking care of a wet bed. It seems remarkable that so many mothers can act faithfully upon their understanding that the child should not be scolded or shamed under such circumstances.

It must seem to many mothers that in giving reasons for not starting toilet training early we are suggesting that they endure the incontinence of the baby and small child for an even longer period. Experience has shown that this is not the case, however. With a minimum of appropriate help many children almost train themselves, as soon as their maturing body systems make this possible. In any case, the old, often strict methods bring the desired results no earlier, for actually the child, in one sense, always "trains himself."

Nurses know of instances which bear this out. One record describes two small children, a year apart in age. The older, three years old, was wet day and night. "Nothing seems to stop the wetting. This child tells everyone she wets herself. Mother is discouraged because she tried hard with this child and it resulted in nothing but temper tantrums. Mother says she started to train this child too early. She is having more success with John with whom she waited."

A recognized difference exists between early training for bowel control and the "catching" of the infant's stool. The following is an excerpt from material relative to this which was prepared and used by a public health nursing agency:

There is a distinction between "catching" and "training." Usually by 3 or 4 months, sometimes earlier, the baby is having formed bowel movements at fairly regular intervals once or twice a day. When this happens some mothers prefer to "catch" these movements when possible. There is no harm in this provided the mother understands and can readily accept the fact that she is not training the baby. It is very hard for some mothers to make this distinction, but it is the nurse's function to help her to do this if she wishes to begin "catching" before the baby is ready to learn.

In material on the same subject prepared by another nursing organization, the importance of the mother's attitude in antici-

pating the baby's bowel movement is made emphatic: "She must stop if she finds herself caring too much for success, becoming emotional and irritable at failure."

Studies of child development indicate approximately the time at which actual toilet training may be safely started, though consistent success at any period cannot be expected. To quote the Gesell and Ilg study, "If the awkwardness of gaining sphincter control were as obvious and comprehensible as that of acquiring upright posture, the training for elimination would become more rational and less emotional."<sup>45</sup>

Dr. Josselyn, in the publication quoted previously in this chapter, says, "... there is a growing tendency to assume that the child is not capable, except under very undesirable conditions of strain, to react to toilet training prior to the second year of life."<sup>46</sup> She is here referring to bowel control. Later she says, "Urinary training, as with bowel training, is not possible without severe strain on the child until the second year of life. Control is generally more difficult to establish and accidents are more frequent. Relapses occur when the child is mildly emotionally disturbed by minor illnesses or is absorbed in his own activities. A child should not be considered enuretic until he is 3 or 4 years of age." Much of the recent literature gives the following convenient criterion: the child is physiologically ready for toilet training at about the time he is able to walk.

The awkwardness and inconsistency with which the child can first assume conscious cortical control of elimination may lead to behavior that seems like problem behavior and actually may become so if it is mistaken for lack of cooperation. There are two phases of sphincter control, one involving ability to retain feces or urine; the other, ability to release it. Such control is further complicated by the fact that the child must set up the necessary associations. In other words, a child may be learning quite well to refrain from wetting or soiling himself, but may be having more difficulty in responding to the toilet seat and therefore in voiding or defecating in the expected place. He then voids on being removed from the toilet, to the annoyance and bafflement of his mother. She may feel that he is doing this on purpose since sometimes he uses the toilet successfully. Of course,



sometimes he is trying to punish his mother, as a rebellion against the difficult training process, which she personifies.

Actual methods of toilet training are familiar to public health nurses and need no repetition here. However, some of the following points may help the nurse in working with parents.

The interest of the young child in his own excretions is a part of developmental behavior. Mothers question the nurse with grave concern about this desire to inspect or to play with excretions. They are relieved by reassurance that this curiosity, perhaps often pride in what has been so recently their own possession, is a reaction common to young children. If this behavior is allowed to pass without emphasis, eventually the child's curiosity is lost in other interests.

The necessity for clothes which make self-help possible seems almost too obvious to need comment. However, the nurse may find this to be a point on which the mother needs suggestions. Small and complicated buttons do not yield in a hurry and discourage the child's efforts. Several records describe the shortsighted policy of mothers who have sewn up the flies on their small boy's new trousers because the child acted "like a baby" in having accidents, and then punished him when he could not unfasten the belt or buttons which held up his trousers. Perhaps this behavior is disguised hostility toward the child rather than lack of perception.

Another suggestion re-emphasizes a point made previously, relative to attention-getting feeding situations. It was suggested regarding the latter that we sometimes advise less attention at mealtimes but do not plan for a more constructive kind of attention at other times. Similarly, our advice to the mother that toilet training accidents and failures be "disregarded" — constructive as far as it goes — may not be rounded out by help with other aspects of the child's life which indirectly affect his difficulty. We suggest to the mother that she "disregard" the child's accidents, but perhaps feel at the same time that it would be rather hard to do so. We sometimes consider that we are not "doing anything" about the problem in making this suggestion. This may be because we fail to see the child's development as a whole, or in the light of previous achievements and security in his family life which may contribute to the new problems he faces.

ening the child. Insistence that the child wash his bed linen may or may not be harmful, depending on how embarrassing or how physically difficult this is for an individual child, and how far he accepts it as a fair procedure under the circumstances.

It would be logical enough to say that the mother is also overemphasizing the enuresis if she shows by covering the mattress with a rubber sheet and pads that she does not expect the child to stay dry. It has been suggested that this practice provides no "build-up" for the confidence the child must eventually gain — confidence that he is able to stay dry. Some dramatic successes have followed when the mother has given the child attractive pajamas and a "grown-up" bed, and has refrained from saying, "This bed must not be ruined." If one looks more closely at this method, however, one sees that the bed must be protected while the child is learning, but has not yet quite learned, to stay dry at night. The successes have occurred when the child is capable of staying dry but may need a little more help, perhaps a demonstration of the mother's confidence, as he finally terminates the training period or outgrows actual enuresis. Similarly, it has helped children in the final stages of staying dry in the daytime to give them appropriate, attractive clothes.

We face a similar need to consider carefully the advice that the child be thoroughly roused when he is taken from his bed to the bathroom at night. It could be said with some truth that the child who is not really awakened at such times is continuing to void in his sleep and so is not really being helped to acquire bladder control. Here one can perhaps make a differentiation between the attempt to toilet train the normal child and the attempt to help the enuretic child. Usually the small child who is being trained is sleeping very deeply when he is roused to be taken to the bathroom, and he may cry bitterly and angrily if completely awakened. His distress and anger may become associated with the whole training process. It is the training period as a whole that needs chief consideration. If possible, one avoids any difficult crisis which can be immediately associated by the child with eating, toilet training, or sleeping. Some small children, however, may wake easily and the training may progress more rapidly because they control themselves consciously under

comfortable circumstances. The enuretic child, on the other hand, is older. Often he, too, sleeps exceptionally deeply. But he will outgrow his enuresis only on the basis of conscious and unconscious desire to do so, and must himself take the lead in learning control. If he is taking the lead, it is safe to wake him up and let him get into his robe and slippers himself and go to the bathroom. If he wants to do so or initiates the idea, he can use an alarm clock and make the whole matter his responsibility.

The parent who is interested in "taking the child up" during the night often asks the nurse at what hours and how often he shall do so. This is not an easy question to answer, and in the long run must usually be answered by the parents. Children void at varying times during the night and must be individually observed before one knows the time when this happens. Nor is this an easy matter. If the child voids more than once, it is hard for tired parents to establish the time of the second voiding. Parents may find it helpful to try the following method, adapted from Waring and Wilker.<sup>104</sup> A child was first roused at ten o'clock and again at two. On this schedule he usually stayed dry all night. The child's mother continued to take him up at ten but gradually made the early morning hour later. After a week she delayed an additional half hour each morning until the child was able to stay dry from ten o'clock until he waked at six the next morning.

Methods which we ourselves sometimes use in such situations may have an effect of which we are unaware. For example, some nursing organizations have routinely insisted on physical examinations, especially urological examinations, before referring an enuretic child to a child guidance clinic for study and treatment. It is possible that this examination will serve to give further emphasis to a condition that is already receiving too much attention. Though a nurse can usually conclude that a child does not need medical examination for his enuresis on the basis of the simple information that he wets at night and not in daytime; that he has no frequency or urgency, or local irritation; and that he is apparently in general good health (this does not include the possibility of glandular imbalance), some nurses may feel that it is approaching too close to diagnosis to make such a recommendation. Since it is difficult for the nurse to give advice in such matters

—though interestingly enough other professional workers who knew less about the child's physical condition would not be bound by the same professional ethics—it may be wiser to suggest that the child's physician or medical clinic cooperate with the child guidance clinic in working out a plan whereby he need not receive another and perhaps unnecessary physical examination that might further emphasize his enuresis. At least some nursing organizations are finding it possible to dispense with this examination as a routine requirement.

Advice to eliminate fluids after a certain time in the afternoon may also emphasize the symptoms instead of reaching the cause of the difficulty. The advice sounds so logical and the habit of giving it is so ingrained in us that sometimes it slips out inappropriately. Some physicians, including some psychiatrists, recommend giving a larger quantity of fluids earlier in the day and restricting fluids in the late afternoon. As one psychiatrist puts it, "Why deliberately burden a bladder when control is as yet uncertain?" Other psychiatrists feel that fluids have nothing whatever to do with the situation, and that restriction of them merely directs the child's attention toward the possibility that he may wet his bed. Perhaps our difficulty has been that we have somewhat automatically advised refraining from or limiting fluids, without trying to learn whether such advice is appropriate. It may be more to the point to study the individual child and to find out how he eliminates his fluids—whether he seems to need two voidings to eliminate his supper fluids entirely; whether he seems to void completely at one time; and at what time or times his bedwetting occurs with reference to fluid intake.

Actual enuresis, established and persistent, is recognized as a problem for the psychiatrist unless it accompanies an organic condition which makes improvement unlikely. The article by Dr. Spock and Dr. Hushka previously quoted contains suggestions for the physician whose patient cannot obtain psychiatric help. These suggestions can be adapted to some extent to the work of the nurse. The article states:

... in many cases of persistent enuresis where psychiatric treatment is not available, probably the most constructive procedure is to leave the symptom itself alone. Instead, the physician may well place his emphasis first on cultivating friendly relations with the parents in order to increase

their security and allay their anxiety. This often has a strikingly beneficial effect on the child. Then he will outline with the parents a plan for doing all they can to increase the child's emotional satisfactions in life. Where these procedures are followed, the physician may have the satisfaction of knowing that he is avoiding the mistake of doing things which will be harmful for the child, he may rest assured that he is proceeding along lines which are psychologically sound, and in most cases he will experience the gratification of finding that he has helped the child in his emotional adjustment, possibly that he has effected at least some reduction of the enuresis."

In this discussion an attempt has been made to describe some of the aspects of toilet training with which the nurse comes most frequently in contact and the concepts which underlie the methods. The first section of the chapter showed that the training period ushers in the child's necessity for consciously exerting control in response to external demands and that for this reason it is important for his good future adjustment. Successful toilet training means that bowel and bladder control are started at the appropriate time and achieved by methods which create a minimum of rebellion or overpassivity in the child, and which foster rather than diminish his desire to get on well with other people.

## PLAY

In recent years nurses have been taking a constructive interest in the child's play, recognizing its important relation to the development of the child's body; observing it as an indication of the parents' understanding of his needs and interests; and seeing it as a medium for the development of his social contacts, especially with other children.

To understand a child's play requires knowing many things about him: his stage of muscle development and ability to coordinate; the extent to which he can concentrate on any one form of play material; and the age at which he can be expected to enjoy playing—first alongside another child, then with a group of children, first with a group of both boys and girls, and later with children of his own sex. Understanding a child's play requires also some understanding of the imagination with which he conceives and elaborates his games—the imagination which

invests his play material with a meaning important to him, but sometimes mysterious to the adult. His whole life as a little child is a mingling of fact and fancy because, with everything so new, he has not yet learned to understand reality as well as adults do. Plans for play or promised outings are doubly important to him because he lives more completely in the present than the adult does and "next week" seems to him like infinity.

Families differ widely in their understanding of the activities that are appropriate to children. Any public health nurse would be unable to count the occasions on which she has entered a home where there are small children to find the place in turmoil. The mother tries to do her housework while stepping around her children; she scolds and beseeches but offers nothing constructive in the way of interesting activity for them. The children feel their mother's mounting irritation and respond by crying and quarreling. Some years later these same mothers may wonder why their adolescent daughters are not interested in helping with the housework. It seldom seems to occur to busy mothers of preschool daughters to help their children join in the housework by allowing them to carry dishes, polish a dish at dishwashing time, make beds, knead a small piece of dough to go into the oven with the baking. This is play to the child, but play is the child's work and his training for what adults know as work. "Household toys" are recognized as a means for helping small girls acquire feminine interests, and tools and construction toys and odd jobs help boys in the same way. Invaluable as nursery schools are, it is ironic that a child must go to nursery school to develop household interests. Such play merges into companionship with the parent of the same sex as the child grows older and as increasing identification with that parent becomes possible.

It may not be enough to suggest to the mother, "Why don't you have the children help you?" This makes a hardship of the whole affair. The mother may lack imagination or may be too fatigued to visualize the far-reaching purpose behind what the nurse is suggesting.

One nurse, who found a mother attempting to bake hampered by her tripe of small children, asked the mother how she herself learned to bake. The mother replied that her mother had taught

her. The nurse called the oldest little girl, helped her to wash her hands, placed an apron around her neck, and gave her dough and a cookie cutter. The child was delighted and set to work with motions so much like her mother's that the mother turned to the nurse and laughed. When the two younger children started a rough-and-tumble on the kitchen floor—perhaps to get their share of attention—the child, late the ringleader, turned to them and said, "You play quiet now. We have to do the haking." The same satisfying results have been shown time after time when the nurse has chosen her opportunity carefully, and has demonstrated what she advised, in cases where she knew the family well enough to do so.

Another home offers a contrast to this familiar situation. The mother explained to the nurse that she always had a plan in reserve for interesting the children. This was by no means always a new toy. She said she never knew when the restrictions of a rainy day and the exhausting of the children's own resources might demand help from her before the quarreling, crying stage was reached.

Children whose lives have been so interesting that they have seldom reached this stage may be richer as adults in resources for enjoying life. One mother, after her son was a grown man with many satisfying interests, read the diary which he had written as a small boy. Every day's record ended with the words, "Had a nice time."

One organization suggests the following points which the nurse might notice when observing the child's play:

*Sustained interests.* Constructive activities so interesting to the child that they hold his attention over a considerable period of time. (The nurse needs to know what play is suitable and what the expected attention span for various ages is. "Constructive" does not mean "construction toys" but implies play material which helps the child to develop.)

*Scattered interests.* Enough toys, but poorly planned and failing to hold the child's attention or to teach him.

*No toys.* After four months, this is significant.

*No playmates.* After two to three years, this is significant.

The following illustration from a nursing record shows a nurse's use of the suggestion:

Baby (13 months) seemed to have nothing to play with. Asked mother if he liked to use his hands. Mother said she could not afford to buy him

toys. Nurse showed her how baby could play with kitchen tins. Mother was interested in this. Mother suggested that her patent can opener left smooth edges and baby could play with clean cans. Nurse inspected and agreed. Told mother she would use suggestion with other mothers.

The child's play has other functions. It helps to give outlet to aggressive feelings. The bloodthirsty nature of the young child's games sometimes alarms a mother who is unaware of this aspect of his play. Here enter the divergent points of view as to whether children shall be given soldiers and miniature war weapons as toys. One group believes that toy soldiers train the child to have warlike feelings and accustom him to war as a possibility. Others feel that toy soldiers are a comparatively harmless medium for getting rid of some of the hostility which living with other people in this world is bound to engender and which is perhaps a human characteristic.

A child often feels hostility toward individuals in his environment, but because such a feeling is "bad" and he is afraid to express it, he represses it. However, it is legitimate to express this feeling in his play. If one observes children who are "playing house," for example, one notices that dire mishaps sometimes befall a child or doll who represents a parent or a sibling. Or the child himself may take the part of a parent and speak sternly to his "children." Hostility is often directed by the boy toward the father in his game because he thinks of his own father as a rival. Similarly, the girl may wreak vengeance on her mother in play.

This play with toys and other persons is not only relieving and therapeutic for the child, it is also diagnostic. It is used in both ways by the psychiatrist. Often a child will express in his drawings in the psychiatrist's office much of the difficulty which underlies his apparently unrelated symptomatic behavior. For example, a small boy who was referred by a nurse to a child guidance clinic because of destructiveness drew pictures of his own home. These showed him at a window looking out triumphantly while a figure supposed to represent his father vainly tried to get into the house. Finger painting, too, reveals as well as helps the child by enabling him to combine a moist medium, color, and design in picturing his story. A child may also express himself by modeling clay. Some clinics have a wide variety of toys and other objects for the child to choose from to express, for example, his reaction in coming to



the clinic. One child chose a popgun with which he "shot" the psychiatrist throughout his first interview. The psychiatrist was glad to endure this treatment for the sake of an improved relationship in the future and, in fact, found it easier to face than the hostility of the adult patient, repressed by convention and finding its outlet more slowly and indirectly.

Whether or not a child plays happily and creatively depends to some extent on whether his parents have interests of their own. The way in which a small boy learns and develops through activities shared with his father, and the fact that the small girl needs her mother in the same way have been discussed. But recreation and interests which the parents enjoy together, or possibly the talents or skills of the individual parent — aside from the skills of the regular working day — give the child an expectation that days can be amusing and interesting, and perhaps some awareness of how to go about making them so. The nurse visits in homes which show great contrasts in this respect. It is difficult to know why some families lack resources and have "blunted" reactions in spite of average intellectual endowment, financial security, and apparently satisfactory family relationships. Perhaps as children the parents of such families were never shown the "distant hills." Perhaps their attempts at experimentation were defeated and their clumsy efforts to help in activities at home were not recognized.

### DISCIPLINE

Nursing records frequently have carried the comment, "Mother's discipline very poor." The supposition sometimes is that "disciplining" is one of a number of skills which the mother may or may not possess. It might also imply that success in this skill can be measured by the child's obedience, without relation either to his phase or rate of development or to the family situation as a whole. Teachers in the public schools have had the same view regarding "discipline" in the classroom, but are rapidly outgrowing it. Now, when a comment to this effect appears in a nurse's record, usually at the end of the write-up of the day's visit, it is really a summary of the whole family situation as it relates to the child. What the nurse is feeling for may be something like this:

"Mother's relationship with and understanding of the child is very poor."

In other words, what we may have been calling "discipline" depends upon all the factors regarding the child and his parents that have been under discussion, for discipline is related to the whole family way of life. This sounds portentous, but it is less alarming when one remembers that the human way of life inevitably includes moments of emotional immaturity and ambivalence on the part of both parents and children. Realizing this, a nurse was undisturbed when a mother said about her year-old baby, "Most of the time I love him; but sometimes I could open the window and *throw him*." Then, thoughtfully, "And I'm not being too funny, either."

In fact, "peace at any price" is thought to be inappropriate as a family motto. Agreement between parents simply for the sake of harmony is not enough. An article entitled, "Why Family Harmony?" puts this as follows:

The essential harmony is not only likeness, but mutual tolerance, mutual understanding, reciprocal affection and appreciation. It is rather a *joint purpose* of family living and parental responsibility. Where this exists, other conflicts may rage without injury, nay the child may apparently thrive on them. . . . Such harmonies as are essential to the child's welfare will come, not from seeking harmony as an end but as a by-product of intelligent interaction with the developing child as its objective."

The ideal of the impassive parent may well be looked at askance. The parent who is never angry, never wrong, is bewildering and irritating to the child, who is often angry, often wrong. What the parent does when angry, and whether he has courage to make amends if he has been inconsistent are more important. Later, outside the home, the child — as child and adult — will meet anger and inconsistency in others often enough. If, while still within the home, he has seen that such feelings on the part of others can be safely weathered, he has learned something of value. This is different from the discarded idea that the baby is helped by the frustrations of a rigid feeding schedule. The latter are intentionally imposed, while the former occur because of inevitable human error and the limits of any adult's ability always to be his "best self."

Many times a day, however, the whole way of family life is

brought into focus as parents try to respond adequately to the child's requests, demands, or bits of behavior. Mothers often say that the child's behavior or questions take them by surprise. Again one sees the value of anticipating with the mother some of the behavior that children commonly show in certain stages of their development. For example, a mother may not know that negativism is an expected part of the training period, when a child is beginning to realize that he is a separate individual. "John suddenly began to 'act fresh,'" says one record. "Jumps up and down screaming when can't get own way. Says no to all requests. Mother argues back and forth. She asks him, 'Where has my good boy gone?'"

Anticipation can sometimes be used in the immediate situation to avoid the proverbial "pitched battle" between parent and child. When a mother sees that a pot of water is about to boil over, she lowers the heat or removes the kettle from the fire. When she sees that a child is in danger of reaching the limits of his emotional control, she can divert his attention and substitute another interest. Perhaps he needs rest or food. It has been shown that outbursts of temper in young children occur most frequently just before noon and before the evening meal. They are also observed to occur when parents are especially weary or busy. Sometimes they indicate the onset of acute illness or result from the nagging presence of a chronic physical defect.

The "diverting interest" is sometimes superficially interpreted. Waiting until a child is hursting into tears or about to scream with rage and then hastily pointing out the view from the window is not what is implied. In one instance where this was done, the child cried with renewed resentment and said, "Don't say 'see the man'; don't say 'see the man.'"

To insist on letting the difficulty come to crisis and then battling it through may indicate hostility on the part of the adult rather than "good discipline." The following excerpt describes discipline which may be of this nature, especially as it shows the mother's compulsive and punishing way of training and the baby's reactions to it:

Mother says the baby is stubborn. He has temper tantrums. Mother says she cannot understand this for she has tried hard enough with him to have him perfect. Observable that his tantrums anger and exasperate mother.

She tells him she will get the upper hand, that she is his mother. Family live in a furnished room and entertain in the evenings. Child does not get enough sleep. . . .

As we review training situations such as those which have been discussed in this section, or think about past situations of this nature that we have known as public health nurses, or consider families in our current case loads, we realize how alive this part of our work is, how on-going and productive it can be. Perhaps this is purpose and impetus enough. But, if we can be sufficiently observant and perceptive in our work with the child in his family, and can record and pass on our experiences in the form of practical, reliable research, we will help in the verification of existing concepts of child development, and will perhaps contribute to them or to concepts which have not yet emerged.

### »» PART III ««

#### *"Problem" Behavior*

Nurses are continually asked by parents for help on problem behavior. A partial list of "problems" which frequently come to the nurse's attention might run as follows: enuresis; feeding difficulties; thumbsucking; temper tantrums and disobedience; masturbation; overaggression; overactivity; shyness; speech defects; sex play; behavior (in older children) that runs counter to the law. An effort has been made in this chapter to show such symptoms, or their beginnings, in their developmental context, since the symptom itself is not the basic problem. Often symptoms do not occur singly, which again implies that the individual as a whole rather than a single aspect of his behavior should be studied. For example, Leo Kanner, in an article called "Mental Hygiene During the First Two Years of Life,"<sup>57</sup> comments on the "spoiled infant syndrome" and lists anorexia, insomnia, constipation, and attention-getting as typical behavior. Irregularities in behavior are commonly described as the overt expression of needs that have not been met during the training process.

Furthermore, it is difficult to discuss problems apart from the child because people do not agree on what constitutes problem behavior. Opinions vary with background and perspective. A cer-

tain mother brings her child to a child guidance clinic because he has temper tantrums. But the psychiatrist's view of this particular situation is that, given the inconsistency of his home circumstances, the child would be showing abnormal behavior if he did *not* have temper tantrums. Again, to students of child development, marked shyness and inactivity are two of the more serious forms of problem behavior; to other persons, this same behavior may seem a blessing.

The traditions and customs of the society or neighborhood in which one lives determine to some extent what one calls problem behavior. Added to and woven into such collective judgments are individual standards and compulsions, some of which have been discussed. Lack of "cleanliness" during the training period is a problem to one mother; to another, it is of no concern whatever.

Studies have been made of the attitudes of various adult groups in close contact with children — parents, teachers, and nurses, for example — to find out what, in their opinion, constitutes problem behavior. The well-known study by E. K. Wickman is one of these.<sup>103</sup> As one conclusion, it shows that teachers who took part in the study considered aggressive behavior on the part of the child more serious than marked shyness. Other studies have shown comparable results.

To say that certain difficult behavior on the part of children is symptomatic is not to minimize the importance of the symptom or the difficulty that the behavior causes at home, on the playground, and in school. It is true, however, that the symptom has a background which we need to study if we are to understand the situation well enough to be helpful; it is also true that the "seriousness" of the behavior is open to various interpretations. For example, it is difficult to compare statistics on juvenile delinquency gathered from different parts of the country because of the widely varying interpretations by police departments and juvenile courts of what constitutes *juvenile delinquency*.

The following questions, which summarize previous discussion, may serve as possible guides to the nurse's evaluation of the situation:

1. Is the background of the symptom understood as far as possible?
2. Is undue emphasis being placed on the symptom itself (for example, by spanking, shaming, scolding, or setting up exaggerated restrictions)?

3. Is the child given appropriate credit for success?
4. Is an attempt being made to replace the unwanted behavior by relationships and interests which can be actually more satisfying to the child than the results of his "problem behavior"?

Two difficulties relate to the fourth point. Suppose that the answer to this question is "No." There is a danger that the attempt to meet the problem as suggested in the question will be on a superficial level — that it will not take the total picture into consideration. Witness one of the simplest and commonest of "problem" situations. A child in his second year sucks his thumb. As the nurse sees the background of the habit in this particular child, he is using his thumb because he has inadequate play material. No early feeding difficulties were present, the mother's flow of milk was normal, and the baby clearly is loved. She suggests that the mother stop scolding the baby for sucking his thumb and instead "keep his hands busy." However, it is not his hands alone which must be "kept busy," but the whole developing baby, if the interests which are offered him are to be an acceptable substitute for his thumb. If he has been playing with a wool rabbit, has thrown it to the floor, and has had recourse to his thumb, probably he will continue to prefer his thumb even though his mother, busy with her housework, detours past him to return his rabbit. Sometimes, with even less success, we suggest that the child who masturbates habitually during the day have his hands kept busy by play material, without deciding what kinds of materials and activities will be really interesting to him and without understanding the lack of security which may be feeding his recourse to himself.

Another difficulty is that supplying the child with alternative interests is not in itself sufficient. More is usually required than replacement of an outworn toy by a new one. The satisfactions of some momentary form of behavior (such as attention gained through tantrums or food refusal, or the infantile pleasure sometimes derived from enuresis or continued bottle feeding) can only gradually be replaced by the interest and excitement of more self-reliant behavior, which in time brings new worlds for the child to explore. Sometimes this long-term form of substitution seems not quite real to the nurse and therefore cannot be made a reality to the parent with whom she is working. Perhaps the difficulty in

such an instance is that she still thinks of the child's behavior as the problem rather than the symptom; she still has only a "dutiful" respect for the slow-going approach to a difficulty which actually has to do with the whole development of the child and his relation to his family.

During and after World War II many of us had opportunity to work with children who showed not a new kind of problem behavior, but a tragic intensification of difficulty because of war experiences. These were the displaced or evacuated children, some of whom are in foster or adoptive homes in this country.

If we need evidence of the validity of the better established and understood phases of child development, the behavior of some of the children in these homes goes far to supply it. Many of them lost parents, other family members, home, and native land. "I wish I were a year old," or "I wish I were a little girl," Editha Sterba reports some of the older children as saying.<sup>44</sup> At the age when, we believe, children depend on the security of relationships with parents and the protection of roof and food for their continued psychological development, these vanished. Not only the traumatic way in which some of these losses were experienced, but the subsequent necessity to suppress emotional reactions in order to preserve life have added to the difficulty of helping some of these children, who are now in good homes.

These children lost, as we say, "everything." As shown in treatment, however, the traumatic loss that seemed to be specific was the lack of opportunity to develop that relationship with others which is thought to be appropriate to each phase of a child's growth. Perhaps beneath the child's saying, "I wish I were a little girl again" lies the meaning, " . . . so that I could have what I needed then and could try again."

Similarly, Anna Freud and Dorothy T. Burlingham, in their study of the reaction of young children placed during World War II in the Hampstead Nurseries in London, found that maintenance of a relationship between the child and parents was more essential to the welfare of the children than physical safety. Their effort was "to maintain the remnants of the parent relationship as far as possible and simultaneously to prepare for the return of children to their homes after the war."<sup>45</sup>

Probably few of us need "proof" of the intense reality of the

relationship between parent and child. But the study of these displaced children will help us, as the study of illnesses and problems has helped us, to avoid the conditions and the mistakes that caused their difficulties.

The "behavior problems" we have emphasized so far have been primarily psychogenic in origin. Perhaps it is safe to say that the majority of such difficulties that come to the attention of the public health nurse will be of this kind. However, in her awareness of this, the nurse cannot forget that some of the problems with which she is confronted may result partly or primarily from organic change or defect. The proverbial "fall" may actually have resulted in injury; the enuresis may be based on a diseased condition of the urinary system. A personality change may have occurred following a recognized or unrecognized case of encephalitis or meningitis. Less fully understood organic causes may unite to produce overactivity or lack of coordination in a child. A considerable number of children who have created difficulty in classrooms, in the neighborhood, and at home have been found, on the basis of electroencephalogram, to be suffering from petit mal, though their condition was unrecognized by those who knew them. Often medical treatment can help such children to the point where they are successful at home and at school. Nurses will find their knowledge of neurology invaluable and, in fact, may want to find ways of adding to it; for when actual neurological problems present themselves, only specific understanding of the condition prepares us to assist in the care of the patient and to work with his family.



## Chapter 5.

# NURSING THE SICK PATIENT

### »» PART I ««

## *Attitudes toward Illness, Disability, and Bedside Care*

A discussion group of nurses in the South was struggling with our ever-present problem of helping the tuberculous patient to accept sanatorium care. Several nurses had described instances of families where progress seemed imperceptible. After a pause another nurse said, "Of course, you can't *make* a patient get well. Even if you trug him off to the San, you can't *make* him get well." The group knew this nurse was speaking truly. As a matter of fact, she had pointed up much of the basis for the nurse's work with patients which this book is discussing, especially the accepted fact that the physical and the emotional are inevitably tied together in all that the individual does and in his varying degrees of health and illness.

His constitutional make-up and all his experiences unite to determine not only his total reaction to illness—including his reaction to the severity of the illness, to recovery, recessions, and remissions—but also his reaction to the kind of illness he has. The individual's illnesses as a child, the reaction of his family toward them, and his experience of illness in those close to him—in connection with the difficult responsibility he may have had to carry—affect the way in which he faces illness as an adult and the importance that he may attribute to it.

We recognize this as the "psychosomatic point of view," a way of thinking which has become increasingly accepted and useful, even though many people dislike the term itself because it seems unwieldy and formidable and even implies that the individual can be divided into two parts—psyche and soma. Perhaps both the term "mental hygiene" and the word "psychosomatic" will some day drop out of our vocabulary, when the concepts they represent have become so much a part of common understanding and experience that they no longer need special emphasis.

"Psychosomatic" has been used in two ways in the comparatively few years during which the term has been current. One way has been its over-all use — to mean the recognition that all medical diagnosis and all medical and nursing service are based on both psychic and somatic factors and on their interaction. This is another way of saying that we are "nursing the patient, not the disease." This over-all concept is being increasingly implemented by the developing diagnostic skills of the physician and the resulting therapy and nursing care. It would not be too much to say that all nursing function is within the area of the psychosomatic when one gives the term its over-all interpretation.

The term psychosomatic has been used in a second way as applying more narrowly to certain illnesses which clinical experience and research have shown to possess a large psychic component. Among illnesses most frequently cited in current medical literature as ones in which careful evaluation of psychic factors is important are: asthma and various urticarias and other allergic conditions; the many variations of diseases of the gastrointestinal and urogenital systems; tuberculosis; cardiac disease; and goiter. According to Dr. William Menninger, the classification "somatization reactions" was used by the Army to describe such illnesses when specific diagnosis was involved.<sup>69</sup> "Somatization" was preferred to "psychosomatic" because the latter term had come to be recognized as referring to a point of view in the discipline of medicine as a whole.

The manner and extent to which psychic factors play a causative part in illness differs with the individual. In the case of illnesses where causative factors still are not clear, as in poliomyelitis, studies have attempted to discover whether or not there is a describable or typical personality which is commonly a victim of such diseases, and also what is the long-term effect of such illnesses on personality functioning.<sup>70</sup> An attempt has also been made to describe the "migrainous" personality and constitution and other such possible entities.<sup>5</sup>

The personality and situation of the patient plus his physical constitution and condition *and their interrelations* increasingly form the basis for his diagnosis and treatment during sickness and convalescence. The ancient concept that all psychic symptoms must be founded on a diseased organ has long been abandoned,

it became increasingly evident that emotional complications, although secondary in nature, created physical disturbances which in turn exaggerated the convulsive symptoms. This psychosomatic concept is by no means new in the field of medicine but has been little utilized by those responsible for the physical care of patients with epilepsy. The work and observations of the clinic amply confirmed the importance of the psychosomatic concept of epilepsy and offered the opportunity for evaluating and comparing the contributions of both physical and emotional components to the causation of the disease.<sup>20</sup>

### THE NURSE'S ATTITUDES TOWARD BEDSIDE CARE

As a human being, the nurse is subject to illness herself and, both because she is a human being and because she is a nurse, she is influenced by and has a part to play in illnesses in her own family. In this same way she is part of "the people" in time of epidemics. One cannot lose sight of the nurse's personal experience of illness in discussing her attitude toward illness and the care of sick patients. Bedside nursing is another part of her experience which affects her relation to this aspect of her service. Whether or not a public health nurse includes it in her daily program, bedside nursing was her first professional experience and so it exerts a continuing influence on her professional life and always has her interest. And illness, as one link in the chain of the patient's experiences, will occasionally appear in those with whom she works.

One of the characteristics of bedside nursing is the far-reaching demand it makes upon the nurse. Like the physician, the bedside nurse must cleave through individual and social confusions in order to deal expertly with the particular crisis in human life which she has been engaged to meet; she must do her work with unrelenting reliability. Even the skilled nurse occasionally makes a serious error. But when she does, the results are so grave and so conspicuous that they may become headline news. Bedside nursing requires not only technical precision but an accumulation of experience and maturity which makes it possible to understand the feelings of the sick patient — what his illness may mean to him and his family, what the nurse and the procedures she must carry out may mean to him — and her own feelings toward the patient and the job. In a unique way this activity frequently demands from

ance. Bertha Harmer, teacher of student nurses and author of nursing texts, once expressed this to a group of young nurses by saying that this growing manual skill would be one of the most satisfying experiences of their lives.

An eminent physician said that he considers nurses as a group more than usually stable persons. His comment may or may not be justified. If he is right, it may be that nurses owe their stability in part to the hard-won manual skill which is so necessary to the welfare of others; and the public health nurse whose program includes bedside nursing may well be considered a fortunate person in that she is called upon for this kind of physical effort and for the skilled use of her hands. It is at least an interesting conjecture that bedside nursing, with its balance of theoretical background and manual skill and physical activity, forms a peculiarly satisfying outlet for the emotional pressures to which nurses, like other human beings, are subjected.

Still more important, the bedside nurse who achieves manual skill is a boon to the sick patient. Her trained hands are a medium through which she gives him the comfort and relaxation without which his recovery is retarded, since it is known that irritability and tension can prolong illness.

Another characteristic of bedside nursing has an important effect on the nurse's attitudes. When she comes into the home to nurse the sick, she is badly needed and very welcome. The resistance discussed elsewhere in this study is practically nonexistent under these circumstances. If she is a skillful, understanding nurse, she is valued by the family even though the patient must die. Anxiety and fear have been crystallized by a definite, painful situation which the nurse can always meet to some degree. While a period of acute illness may be no time to work with the family on problems not connected with caring for the patient, at least the nurse has opportunity to recognize the problems. Later the interest aroused in the family by her work may give her a teaching opportunity that otherwise would not have been open to her.

One aspect of bedside nursing affects primarily the attitude of the nurse herself. Promotion customarily takes her away from bedside nursing. In this country most staff nurses want to become supervisors, or if they do not, our standards are such that they feel they ought to make the effort. This desire may have no rela-

tion to the executive or supervisory ability the field nurse may have. As a matter of fact, the field nurse who seeks such "promotion" often realizes with fear that she will be expected to direct other nurses. Reasons for the nurse's wish to become a supervisor are easy to understand. For one thing, supervisors are usually paid higher salaries than staff workers, which means that they have more comfort, or an opportunity to save, or that they will be able to care for possible dependents. The older nurse may be unable to endure the days of hard physical work which are expected of the field nurse. And there is another more intangible factor. It has to do with social pressure and with the idea that supervisory positions carry more prestige than staff positions. We are trained to think that success is synonymous with promotion. The fact that a nurse may thoroughly enjoy her field job, with its direct contact with sick and well patients, apparently often counts for little as compared with the recognition of ability indicated by promotion even though she may enjoy her new position far less than her former one. Bedside nursing may become something to be left behind as soon as the public health nurse can climb another step up the ladder which social pressure rather than an individual sense of values may have set in place. This is an involved problem not limited to the nursing profession and one for which we seem to have no comprehensive solution as yet.

The nurse's attitude toward bedside nursing is influenced by other more individual considerations. Since bedside nursing is a primary activity of the student when she enters training, this service must be closely tied up with her reasons for entering nursing school and for wanting to become a nurse. We are increasingly familiar with the fact that the reasons we give ourselves and others for our behavior are not always the real reasons for the things we do, even though we may think they are. It seems safe to say, however, that the majority of students who enter schools of nursing with a lasting interest in nursing are motivated in varying degrees by a wish to be of service. This feeling the nurse has in common with other professional workers such as teachers, social workers, ministers, members of the medical profession. The need to give is more directly and simply satisfied through bedside nursing than through nursing activities where contact with the patient is indirect or where the patient's need is less immediate.

Catharine Cox Miles of Yale University, a psychologist interested in nurses' problems, has compared the attitudes of young nurses with those of college students of the same age group. She says:

Their [the nurses'] special divergence from others in their age group, of equal intelligence, equal education, and comparable social experience, is in their sense of awareness of suffering — they show the social emotion of pity. While being like other young girls in the primary emotions, *fear*, *anger*, and *disgust*, they rate at a point on the *pity*-scale which means that this emotion is for them not a theoretical one, but a basic starting-point for their life interest.<sup>21</sup>

However, the study does not go on to consider individual reasons which may have brought the young nurse into the group of those who feel this pity.

Many of us feel that we should conceal this wish to help others as though it were a blemish. One wonders why. What is so embarrassing about wanting to be useful? Perhaps this is just our American offhandedness. Perhaps the need to conceal a wish to be of service is another of the pendulum swings, this time a swing away from the zeal necessary in the pioneer days of the profession — the zeal most of us cannot emulate. We may also be embarrassed because we realize that an exaggerated desire to serve others usually cloaks some other unrecognized feeling and therefore is not a sound basis on which to build a professional life, although it may be helpful to the individual nurse.

It is essential to know whether or not the young nurse's need to give of herself is her own, or results from family standards to which she — perhaps an immature person — consciously or unconsciously feels she should conform. Dr. John H. Stokes speaks of the "excessive altruism" sometimes seen in members of the professions previously mentioned.<sup>22</sup> He refers humorously to such altruism as, in some instances, "hereditary neurosis" in describing the influence that family standards can have on the choice of work of succeeding generations. If the student has entered the school of nursing more under the influence of her family's ideals than through her own choice, she may find bedside nursing repugnant and either give up nursing altogether or, if her interest is genuinely caught, find a real place in a branch of nursing which does not include bedside work.

An exaggerated need to serve others may also be based on unhappiness or anxiety unattached, as far as the individual knows, to any specific incident, or on regret over a particular happening that she wishes to repair in some way. Nursing, especially when it includes bedside nursing, is hard work. It is also service to others. It affords an opportunity for the young woman, burdened with anxiety whether or not she is aware of it, to work some of her conflicts out of her system. Actually she does a form of penance. Some persons need to continue doing penance for the duration of their lives in order to be at peace with themselves. Others are somewhat surprised to find after a period of nursing service that they no longer want to be nurses, and especially that they no longer want to do bedside nursing. Evidently the unconscious penance is over. Perhaps they leave the nursing profession. Or again they may become interested in nursing for sounder reasons and continue in the work.

Most of us have some need to mother our patients, especially when they are ill or in difficulty. To quote again from Dr. Miles's study, "This protective, idealistic, maternal attitude and urge tends. . . to differentiate them [young nurses] most clearly from other groups."<sup>11</sup>

It is not too much to say that the oversolicitous bedside nurse can retard the convalescence of her patient because of her need to baby him. The very helplessness of the sick patient turns him from his mature goal and temporarily heads him back toward infancy. If the nurse unthinkingly takes advantage of his helplessness to overmother him and oversympathize with him, his return to self-reliance may be retarded.

In addition to women who enter the nursing profession because of a desire to care for suffering individuals there are others motivated primarily by the desire to aid in clearing up ignorance and misapprehension and the waste and confusion that result. The ability to promote order is characteristic of all successful nurse executives. However, in a nurse who has a need to dominate, the love of order may become so exaggerated that it hampers rather than furthers effective work.

We are accustomed to describe such a nurse as "authoritative." In the hospital she is the starched, militaristic martinet; in public health nursing she is the executive who must completely dominate

her staff, or the field nurse who "tells" the patient instead of teaching him. We are accustomed to say about this dominating person that there are fewer of her kind now and to speak of her as the "old-time" authoritative nurse. Or we say that her methods may be necessary because very often precision is needed to safeguard life. The psychiatrists reply that in making this latter point we may be putting the cart before the horse. Granted precision is necessary, it is still not the job that creates the authoritative method, but the opportunity to exercise authority that calls to it the person who enjoys doing this. Some nurses have a need to exercise authority, just as others have a need to serve the individual patient. One can conceive of several situations in the early experience of the authoritative person which may have contributed to this need. Later in her professional life she continues the pattern that was set by these early experiences. Perhaps at one period her prestige suffered in some way and she is now compensating for that rebuff. The saving part of the situation is that realization of some of these factors is leading to less rigid methods of nursing education and to a broader concept of nursing, with the result that overauthoritative nurses are beginning to seem to other nurses as maladjusted as they appear to the layman.

Techniques and procedures, if they are considered important in themselves and not merely as a part of the care of the patient, may lead to an exaggerated emphasis on organization. For instance, a nurse who is concerned mainly with nursing procedures may seem not to appreciate her patient's sufferings and so does not relieve them, though in reality she is far from being unsympathetic. We should be mistaken if we considered that all nurses are actuated by the motives of pity and the understanding of suffering previously described. Skill in techniques and the wish to relieve suffering do not necessarily go hand in hand. A nurse, like members of other professions, may enjoy the sense of power gained by the actual manipulation of tools and of people, without direct sympathy for those whose illness or health problem is the crux of the situation. Some few nurses lack imagination and therefore are slow to grasp the needs of the patient. Others are more or less impervious to the fact of pain because of their interest in the procedure they are carrying out. Experience in conserving her emotional energy throughout days habitually spent in the pres-



ence of pain or discomfort helps to give the nurse the poise and emotional equilibrium necessary to do her work. But it does not seem likely that such experience would make her callous to the sufferings of patients, although the accusation is often made. It is more likely that her interest in techniques and the routine of the job is characteristic of a long-standing behavior pattern.

Emphasis on techniques may result in part from a rigid type of training rather than from a nurse's previously established emotional pattern. The following excerpt from an article by Dr. Karl M. Bowman is a humorously exasperated, but merited, comment on this point:

I would like to re-emphasize the danger of stereotyped routine and the necessity of constantly reviewing all administrative and clinical procedures with a willingness to discard any procedure which is unsatisfactory. . . . We may become so interested in structure, in organization or in the correct running of the institution that we lose sight of the fundamental fact that the test of a good hospital is how well the patients in that hospital are cared for."

In illustrating this Dr. Bowman cites the early morning hour at which patients are awakened in many hospitals, the unusual hours for meals and, apropos of the ambulatory patient's daytime rest and his use of the bed for this, adds, "I have the impression that the great insistence on an immaculate looking bed has been so deeply ingrained in her [the nurse] from her period of nurse's training that it is almost impossible to desensitize her."

Of the many public health nurses who enjoy bedside nursing, some like it primarily because it is the nursing activity in which they have been best trained and which they can best perform. There is security in the familiar procedures and satisfaction in carrying out a skilled procedure successfully. But there is also danger to the nurse in this repetition of familiar techniques. It is possible to use a liking for bedside nursing as an unrealized defense against the broader purpose of seeing the family situation as a whole and then making use of this for teaching purposes — perhaps less familiar ground. For example, emphasis on bag technique or insistence on the exact use of certain procedures may sometimes go beyond the care necessary to safeguard the patient. A nurse may so immerse herself in what she feels to be necessary bedside nursing that she has no time for work with well people, in which she is less secure.

Some public health nurses fear bedside nursing and, perhaps quite unaware of this fear, merely think that they do not like bedside work. This fear may be based on dread of contracting a communicable disease from the patient. Nurses might consider such an attitude cowardly and so suppress it. For example, fear of tuberculosis is widespread among adults, a reaction which doctors and nurses do not entirely escape, especially when their work brings them in constant contact with this disease or when the experience of a friend or relative makes it part of their personal as well as their professional lives. Dr. E. P. Bledsoe in his book, *The Psychology of the Tuberculous Patient*,<sup>15</sup> describes such fear on the part of an intern who was quite unconscious of his feelings in this respect until one night he dreamed that he was undergoing hemorrhage after hemorrhage from the lungs.

As an illustration of such fear in a nurse, a situation comes to mind in which a field nurse could not see the obvious importance of frequently dressing a patient's draining tuberculous sinus, though no one else was available who was capable of doing the dressing. This nurse knew she was afraid of tuberculosis in spite of the safeguards offered by her technique. What she had not realized, or had suppressed until she was no longer aware of it, was the connection between her fear and her feeling that this particular dressing was unnecessary. It is this "missing link" which constitutes danger to the patient.

Nurses also are afraid of contracting syphilis from patients who have this disease, perhaps in addition to an acute condition for which nursing care is needed. Much of this fear has been founded on lack of information as to the stages when syphilis is communicable. When the disease is in a communicable stage, fear may create in the nurse a distrust of recognized techniques known to offer ample protection. Accidental infections in well-organized syphilis clinics are practically unknown. Yet doctors and nurses do not escape "syphilophobia."

Unrecognized fear leading to dislike of bedside nursing can also be based on a sense of inadequacy in bedside techniques. Inadequate training and lack of manual skill are obvious contributing causes here. Often this fear is due to the fact that the nurse has not done bedside nursing for some time and therefore has forgotten her techniques, or thinks she has, or is aware that

new methods are in use with which she is not familiar. It is the dislike which is expressed, however, not the fear or the sense of inadequacy which probably lies behind it.

This writer has never encountered the problem of malingering in a nurse. However, that such behavior might well occur on an unconscious level is brought out in an article by I. R. Somenthal entitled, "Malingering in Nurses with Hysteria." He says:

The nurse's psychological situation is not an easy one. A nurse has to take care of other people whether she feels well or not. . . . Whenever her dependent tendencies are aroused, this is greatly increased by being continually exposed to sick people who have the right to be taken care of by others. . . . That they [nurses] occasionally succumb to temptation and wish to be sick themselves is quite intelligible. This wish to escape into sickness, together with the opportunity and a knowledge of the different symptoms, would seem to make them easier victims of malingering than many people who are not exposed constantly to this type of emotional difficulty characteristic of their profession."

*It would be sad indeed if nurses began to spend a large part of their time bunting for their own hidden motives. To a certain extent we must take ourselves for granted, without too many attempts at self-analysis. But the fact remains that there is a dynamic basis for our attitudes, and we often do not recognize what it is because it would be painful to do so. Unconsciously we protect ourselves from this unpleasant experience by making a more acceptable interpretation of the way we feel. Our own experiences and relationships color this interpretation which, in turn, influences the nurse's method of caring for the sick patient.*

An especially illuminating illustration, furnished by a large organization which is responsible for most of the bedside nursing in a Midwestern city, shows how a nurse's work can be hampered when she does not understand her own motivation. This nurse carried unusually heavy family responsibilities as well as a heavy case load. Her elderly mother suffered from a malignant condition requiring careful surgical dressing in the morning before the nurse left for work and again in the evening. For her mother's sake the nurse felt she should make her home in a suburb. This meant a long ride to and from the city during the morning and evening rush hours. The nurse maintained this program month after month. She gave patient, untiring service to her mother. But quite unconsciously she made her patients pay for her own difficult

situation. While she was tolerant with young persons who were ill, she was dictatorial and hard in her dealings with elderly patients, especially those who had illnesses of long standing. She wished to discharge elderly postoperative patients from nursing service before their condition warranted it and unconsciously minimized their symptoms in her reports to the physician. She was impatient with families who, according to her standards, did not take adequate responsibility for the care of the patient. On the advice of a psychiatrist who was a member of the medical committee of the organization, the director explained to the nurse that she was carrying an impossibly heavy burden at home, that her natural rebellion and resentment, which could not be expressed against her own mother, found vent in her treatment of patients in similar situations. The nurse at first reacted against this with great dismay and unbelief. Ten days later she came to the director to say that the latter had been right and that she had made plans for easing the home regime.

#### THE PATIENT'S ATTITUDES TOWARD ACUTE ILLNESS

The theory that childhood experiences, especially the child's relationships with his parents, largely determine adult behavior explains many things in the relationship between the nurse and the sick patient. Given a situation in which a patient receives bedside nursing, it is a foregone conclusion that to some extent the nurse takes the part of a mother and the patient that of a child. The aspect of the "mother" as a tender, pitying person or as one who shows exaggerated sympathy has been described in discussing reasons why women enter the nursing profession. But often a strict mother is also thought of as a "good" mother, whether or not her discipline gives rise to recognized or unrecognized rebellion on the part of the child. Here, then, is another reason why a nurse may seem to be authoritative.

A great variety of childhood experiences further individualize the behavior of both nurse and patient during the period of bedside nursing. Much of the ill patient's behavior — his docility or unreasonableness, his dependence or rebellion, his desire to get well quickly or to prolong convalescence — may be thought of as

a reliving of like experience in childhood. This places a special responsibility on the nurse who gives bedside care to understand herself and her patient. Bedside care as the public health nurse participates in it is somewhat different from that of the private duty nurse who has an intensive, uninterrupted relationship with the patient, often for months at a stretch. The importance of the patient's childhood experiences as they relate to bedside nursing has been developed in clear detail by Mary Chadwick in *Nursing Psychological Patients* (originally presented in lecture form to the nursing staff of the University College Hospital, London).<sup>28</sup> Although this book deals primarily with the nursing of mental patients, what is said applies also to general nursing, both directly and because the line between the normal and the abnormal is not clear cut.

It is true that each patient reacts as an individual. Yet certain emotional reactions common to acute illness seem well enough defined to bear comment here. The three reactions discussed in the following material are fear, regression, and egocentricity. These reactions are described in slightly different terms in a chapter on the social psychology of acute illness contained in a bulletin of the Social Science Research Council entitled, *Adjustment to Physical Handicap and Illness*.<sup>9</sup>

Fear is an almost universal reaction to a grave illness. Except when death is welcomed, consciously or unconsciously the patient may be afraid that he will die. He may show typical symptoms of intense fear when a fatal termination of his illness is practically out of the question. He is afraid of the unknown course of his illness and perhaps very much afraid of mysterious treatments which may be unpleasant or actually painful. He is afraid that his business will suffer without him or that his job will not be held for him. Sometimes we inadequately describe fears about practical matters as "worries." Realistic financial troubles are basic enough to be ranked as fears. The patient may fear for his family if he has family responsibilities. Such fear is related to the dread of crippling disease. Threats to vigor, youth, beauty are added terrors which patients may not express but which are deeply rooted. Such fears, either expressed or unexpressed, can often be relieved to some extent by the nurse.

An opportunity to talk about his concern may be helpful to the patient. The nurse can listen thoughtfully and with interest if he

feels a need to tell her about his difficulties and if he is quieted and relieved by doing so. Being a good listener, however, may not include giving advice, as one often is tempted to do after the patient has expressed his problems. It is the opportunity to share his fear and bewilderment with the nurse which the patient may need at this point, not the added effort of thinking through suggestions for meeting his predicament, though the nurse keeps in mind the patient's possible need for active help.

On the other hand, the patient may be inarticulate, though he shows unmistakable signs of anxiety. Or it may be obvious to the nurse that his words do not express what he feels. In fact, he may be expressing just the opposite of what he is feeling. While he may say that he expects to be up and around again within a few days, he may actually be feeling, "I'll never be the same again." If she responds superficially and without thought, the nurse might congratulate the patient on his optimism, leaving his fears unrelieved. She might suggest, on the other hand, that it would be quite natural for the patient to be somewhat worried about his condition, that sickness carries with it a depression and a feeling of helplessness. These words have an artificial ring since they will be different in every situation, but their purpose will be the same—to speak to the emotion, often fear, which lies behind what the patient says, or behind his silence, and to show him that others who are ill feel as he does.

However, what is said to the patient or in his hearing may increase his fear. Since the patient is afraid, and is therefore not a very rational being, he frequently misinterprets conversation that he overhears. Both doctors and nurses may make casual remarks near the bedside of a patient which are interpreted by him as referring to himself, and which may be so amplified and distorted in his imagination that they lead to the perpetuation of his symptoms, so that his illness becomes chronic. Or a physician or nurse may use professional "jargon" which is wrongly interpreted by the patient. This "jargon" may be used deliberately in an attempt to mask the meaning of the words. Medical literature points out that a casual, unthinking interpretation to the patient of a diagnosis of cardiac disease may crystallize all his formerly vague anxieties and center them about his heart, to the intensification of his illness. Frequently it is the nurse's task to interpret

the doctor's diagnosis further to the patient and his family. Her explanation must not add to the patient's fear and create oversolicitude on the part of the family, yet it must clarify the patient's condition sufficiently to assure adequate care.

Some of the patient's fear is due to ignorance of the purpose and method of treatments or to dread of painful treatments. These procedures are all in the day's work to the nurse. She may not realize how mysterious and fearful they seem to the patient. Her silent, purposeful collecting of equipment at the bedside may well be watched by the patient with a feeling of misgiving which could be relieved by explanation. More harm than good follows an attempt to gloss over the fact that a treatment will be painful or disagreeable. The emphasis at such times might be put on the expected result of the treatment. Here again, generalities are not helpful. "This is for your own good," is one of life's most exasperating inadequacies. But if, for example, the patient's body is parched for lack of fluid which he cannot take by mouth in sufficient quantities, he can understand something of the relief and relaxation which will follow intake of fluid by other means.

Prejudice against certain drugs or treatments may be based on superstitions or religious laws which the patient is afraid to transgress. Ill-founded as some of these may seem to the nurse, they are realities to the patient. If one is able to modify the treatment until it is in accord with family or racial customs, the patient's fear and resistance are diminished and the treatment has more chance of benefiting him.

The nurse often helps actively when the patient's fear is fed by anxiety over family or business. If a mother, ill at home, sees that the children are unkempt and unsupervised or that her husband is not having proper meals, her recovery may be retarded by her anxiety. The man of the family, ill in bed, is equally tortured by mental pictures of confusion at his office or by a conviction that another man has been given his job. Mere reassurance here is little help because the patient feels that the nurse does not understand the reality of his difficulties and so loses some of his sense of security with her. Usually one member of the family stands out as the person most capable of taking responsibility in the situation. With that person the nurse can plan for needed help. Unless the family is entirely disrupted by the illness they will be

able to work out with her a plan that will fit their needs. The nurse helps best in this planning if she is unhurried and calm and able to show the family plainly, but supportively, how the patient is harmed by existing circumstances. The situation may call for an immediate referral to other community resources.

When it is not possible to relieve fear by methods which require reasonableness on the part of the patient, he can be given security in other ways. The nurse's own bearing and manner can help to give him confidence. A baby senses his mother's muscle tension, reacts to it with fright. In the same way the patient is aware of the muscle tension of the nurse who gives him care. If the nurse is relaxed, poised, serene, able to use her hands without false motions, the patient's tension will also be relieved. Fear is a lonely feeling as experienced by the sick patient. The nurse can help him by making sure that he does not feel "deserted." If he is to be left by himself, he must feel that someone is within call. In other ways, by careful attention to details of comfort, the nurse shows the patient that she understands his pain and discomfort and that in his suffering he is not entirely cut off from other people. Some bedside techniques are planned to add to this feeling of security on the part of the patient. For example, the nurse turns the patient toward her rather than away from her in giving nursing care, not only to ensure that she does not roll him out of bed, but also to give him comfort and reassurance from her near presence.

Bertha Damon, who has had an experience of acute illness, tells us something of her feeling of aloneness in the following excerpt from her book, *A Sense of Humus*:

When you are coming out from an anesthetic, time does not exist. Time usually seems the sequence in which things happen. Here nothing happens. Time telescopes into nothingness. . . .

Out in offices and houses and fields, life is all; in your hospital room, caught in the coils of this monstrous time, life is the receding, the remote, possibility. You are walled away from life. Hospital rooms seem to have vastly more ceiling than any rooms people live in. White and impenetrable, beginning at a point directly over your head and running down and hardening into walls, it is all of a piece.

You are alone, under your ceiling, sick and in prison, and no one visits you. Science thinks it better that no one should visit you "for the next few days." Is there somewhere a hand that might quietly take yours, a face with grave eyes that say, "I understand," a voice that would speak of what is in



your mind? Perhaps, but science would not have your cardiac action upset.

The door opens, and you turn your head a little. ("Oh, let us speak of life, let us touch dear memories!") It is a technician who enters; she pierces your ear for a blood count and goes out.

Again the door opens, noiselessly. . . . It is the doctor and he is taking your pulse. A nurse shows him the chart. You can see his face change. He takes your hand; you press his, believing for an instant that this is sympathy; but, no, his handclasp is merely to confirm the charted report of your temperature. ("Is there nothing to me, then, but body?")

"I have known you a good many years," the doctor says, "so I think I will tell you something. It is not customary to tell a patient, but I know you can take it. It is this"—he hesitates—"you—you have a temperature of one hundred and five."

He looks at you. Is it understandingly? ("Oh, doctor, tell me—is it true that in my father's house there are many mansions? Nonsense—don't ask him anything so foolish—he does not know—the answer is not in *materia medica*!") . . .

Alone again, I and the ceiling. There are none or two persons I should like to see. They and I would have words to say. Only a few words, of necessity; but good.

How lonely birth and death have become. Once all the royal court was at the horning to hear the first cry, and all might be as merry and social as at a reception. Remember all the cozy old pictures of deathbed scenes with the big family grouped around the high feather bed. . . . The expression on the patient's face, pleased and content. . . .

I am lonely. If only there were some companionship in this business. And my feet are cold and floating."

Some of us, on reading the above material, feel defensive about it and tell ourselves that this is not a true picture; that a patient with such a high temperature was irrational. Then we are forced to remind ourselves that this is the way one patient felt.

Partly because of his fear and partly because of his helplessness the acutely ill patient becomes somewhat like a child. A tendency to regress emotionally is typical of the sick patient. Sometimes we accept this fact without thinking how the patient's tendency to regress must affect nursing care, or what it actually means to be childlike. A child is dependent on others for care. He is impatient of restraint and rebels against uncontrollable events. His immediate wants are of more importance to him than the harmful results which may arise from satisfying them. Tomorrow is a long way off as the child conceives of time; he can think only of the moment. In other words, the reasonableness which the adult

may have built up in the course of years may crumble away, though only temporarily if the building was done soundly and if the nurse is helpful to him.

Awareness of the nature of this temporary regression affects nursing care in two ways. In the first place, it helps the nurse to understand the patient's reaction to nursing care and her own reaction to the sick patient, and therefore leaves her more free to work with him successfully. In the second place, it clarifies the danger of overprotecting the patient at this time. It is not safe to make illness pleasanter than health, not only because convalescence may be retarded but because life for some patients is so difficult that, unconsciously, they seek a door through which they may escape without incurring blame or self-accusation. They may, for example, escape into chronic invalidism. While unconsciously aiding the patient's regression, the nurse can open this door to chronic illness. Awareness of the patient's tendency to regress helps the nurse to understand his demands and to gauge the amount of help he needs from her, especially during convalescence. In adding to the patient's sense of security and in contributing, as just suggested, to his ability to face a return to normal living, the nurse reinforces the patient's desire to recover and his capacity for effort.

A nursing record gives the following instance of a mother who enjoyed the attention received during her postpartum period so much that she prolonged her convalescence. The patient had worked very hard since girlhood and had been almost continuously pregnant since her marriage. Now the oldest girl was able to care for the household in an emergency. With the help of the nurse, she also cared for her mother and the newborn baby, following a home delivery. Two weeks went by and the mother still felt that she should be a bed patient, unable to bathe herself or to take any responsibility for the baby although pregnancy and delivery had been uncomplicated. The daughter was growing restless and resentful under her double burden of work and responsibility. Faced with this situation, the nurse and daughter carried out a day-by-day program which helped the patient to take up her normal life. They asked the mother's opinion about household matters to show that her decisions were needed. Gradually the mother resumed the planning of meals and of purchases. After

giving the mother bedside care, the nurse brought the baby to the bedside to bathe him, asking the mother to hand her his clothes as they were needed and placing him in his mother's arms for his bottle after his bath. Soon the mother finished the baby's bath as she sat in bed with materials at hand. When the nurse made her morning call a few days later, the mother pointed with pride to the baby already bathed and in his basket, and to the heap of greens she was preparing for dinner.

Regression can show itself more subtly than in this simple instance. Without an awareness of the patient's tendency to regress, the nurse might miss the significance of certain symptoms, as well as the meaning for the patient of the kind of care he is demanding from the nurse. For example, a patient who had recovered sufficiently to be out of bed and to dispense with the bedside service of the visiting nurse could not bear to be without the nurse's care. "I want you to come every day," she said, "and to give me my bath and rub just as you have been doing." The nurse realized that the patient had felt like a sick child being bathed and dressed by her mother and that she had welcomed this experience. She attempted to put the relationship on a different basis by saying that if she continued to come the visits must be paid for at the full rate, inasmuch as the acute need for bedside care had passed. When the nurse refused in this way to be a protecting, generous "mother," the patient did not want her services. It would have been quite possible for the nurse to have prolonged her patient's convalescence had she allowed her possible enjoyment of nursing a dependent person to cloud her understanding of the patient's needs.

It is obvious that feeding and bathing patients and the management of elimination — basic problems in the care of all sick patients — can contribute to the patient's regression if they symbolize infancy to the nurse rather than the care of a bedridden adult. In the words of Miss Chadwick, whose book, *Nursing Psychological Patients*, has already been mentioned, "the child that remains in the patient readily responds to the mother wish in the nurse to tend the helpless." Especially in the acquiescence or apparent unreasonableness of the patients in matters of food and elimination does one see old childhood patterns relived. The nurse too has had similar childhood experiences. Carrying her

description of the tendency of the patient to regress into further detail regarding bedside care, Miss Chadwick suggests that, in her observation, the symptom of incontinence not infrequently provoked a negative reaction on the part of the nurse.

For this subject especially she seems to lose her grip of her professional knowledge that it is a symptom, and one that denotes severe illness, and not merely a recurrence of childish naughtiness on the part of her patients, young or old. . . . This attitude will usually be the reaction of the young nurse who is very positive and anxious to save herself as much trouble as possible, it is true [sic]; but it is amazing to observe how often it will occur in those who we should have thought would not have allowed their personal feelings to swamp professional obligations and the knowledge they have acquired, yet in this we may also see a clear instance of last to come, first to go, in respect to acquired knowledge cutting across old teaching of childhood.<sup>28</sup>

Though most nurses, remembering how often they have uncomplainingly changed the beds of incontinent patients, may be reluctant to admit this, it nevertheless bears thinking about.

If the patient likes the nurse, the latter can help simply through the effect of her own personality. It may create self-consciousness on the part of the nurse, or even a feeling of resentment, to bring up the question of her personality in this connection. But to a considerable extent it is because the patient wants to be like the nurse who is well, who has vitality, who is poised and, above all, adult, that he welcomes returning health. One can see how important this identification of the patient with the nurse becomes, not only with the sick patient but in family health work as well.

A third reaction to acute illness is the patient's preoccupation with himself. Even when he is concerned with business and family cares, the patient is centering intensely upon himself. The outgoing friendliness, the love of others which may be characteristic of him while he is well are directed to some extent toward himself during acute illness. He is especially preoccupied with the part of his body which is diseased. His illness becomes an important milestone in his life. His demands for attention and his insistence that details be attended to in the way he personally likes best are partly childlike reactions, but they are also partly due to the fact that he has become more than usually important to himself. For example, the patient wonders why the nurse does not come to him first on her daily schedule of visits. He insists that

the table at his bedside he arranged in a certain way; that procedures be carried out in accordance with his individual preference. The authoritative nurse who feels that the situation should be handled "her way" finds this increasingly egotistical behavior on the part of the patient exasperating and unnecessary. Dr. George W. Wright, writing on mental hygiene and psychology for nurses, suggests with regard to this egocentric behavior that nurses, doctors, and administrators must learn to individualize the treatment of patients because there is no time when people are more individual than when they are sick.<sup>107</sup> Dr. Wright points out that when we are well we more easily accept standardization; we can be grouped and disciplined to a certain extent. For example, he says, one can take fifty nurses and lay down rules which in most instances can be observed. But there is no way of laying down rules which would fit every case of sickness. Usually the public health nurse has an infinitely more hopeful opportunity to individualize her care of her patient than the nurse employed in a large institution, though in a number of hospitals steps have been taken in the direction of individualized nursing care.

While these three reactions have been described as common in some degree to all seriously ill patients, their extent is determined by the kind of person the individual patient may be. His attitude toward his illness will depend upon the manner in which he has met former trying situations. Some childhood experiences may still be potent in their influence although the patient may not remember them or see their relationship to his present illness. He may be especially influenced by experiences which related directly to illness.

Illness in the patient's family, especially the illness of his parents, is one of the most far-reaching of such childhood experiences. We know that children suffer physically from exposure to such diseases as tuberculosis. But they also suffer emotionally from the illness of their parents if the parents are unable to accomplish the difficult task of living as normally as possible with their own illnesses. A study of 320 cardiac patients indicates that children with a tendency to "nervousness" and sickliness are found more frequently among those who have lived with cardiac or "nervous" parents than among those who have no such

beredity or who, *having this heredity, have not been in contact with the parent.*<sup>35</sup> In other words, the attitude of the child's family toward illness may be more important for the child's welfare than the fact of family illness itself.

A family known to a visiting nurse association furnishes a case in point. This family consisted of father, mother, and one daughter, eight years old, whom the mother kept with her constantly. The mother had been miserable for years because of a gynecological condition. She described and discussed her symptoms in the child's presence and emphasized her own discomfort and lack of energy. Soon the eight-year-old child also began to complain of gynecological symptoms impossible in a child of her age. The nurse was faced with the problem of helping to improve the child's emotional environment before the foundations of invalidism were too firmly built.

Illness or defect in a brother or sister which requires unusual care and attention from the parents may create a problem in the well child since he, too, has a need for attention. It is difficult for the well child to see the advantage of staying well when his parents' love seems to him to be directed mostly toward his sick brother, often in the form of toys and tempting food. The outgoing child may solve his problem by exhibiting such annoying behavior that his parents are forced to pay attention to him in spite of their preoccupation. Or he may openly show dislike of his brother, to the shocked surprise of his family, who do not understand that a child is not a socially disciplined person who can step aside for others or can at least make an attempt to do so. If he tends to be ingrowing, he may consciously or unconsciously develop symptoms of his own which will give him his share in family solicitude. He may return to infantile habits, or the foundations may be laid for a persistent feeling that as a person he does not amount to much. He may spend the rest of his life trying to cover up this feeling in various ways.

An individual's attitude toward illness is influenced not only by childhood experience with family illness, but by serious illness in those he loves or with whom he is associated at any time of his life. Family illnesses may so affect him that he is convinced that he too is suffering from them or has a tendency toward them, especially when he is aware that the disease is one which appears in succeeding generations. "Pseudo-heredity," this has been called.

Attitudes toward cancer furnish a familiar example. The closer the individual has been to such an illness, the greater his tendency to be affected by it. This seems obvious, but physicians interested in this aspect point out that many medical histories fail to state in connection with family illness whether or not the patient nursed a member of his family or a friend through a difficult or terminal illness or otherwise took heavy responsibility at the time of the illness which might intensify his reaction to it.

The patient's conviction that he has a certain illness may be influenced by other experiences of adult life which have caused him anxiety. For example, a sexually promiscuous person is readily led by a quack to believe that he has acquired syphilis. He is willing to enter into long treatment for the disease without demonstrable symptoms of it.

The patient's own illnesses also leave their mark. Studies suggest, however, that the attitudes of those around him during his illness rather than the illness itself, except in cases of organic damage to the central nervous system, may determine the way he feels about illness and the use he makes of it.<sup>11, 49, 50</sup> Several points of interest to nurses in this connection emerge from the Hardy studies on school children.<sup>49, 50</sup> Findings indicated that "children whose training schedules were most frequently interrupted by sickness during their early years were *least* likely to manifest behavior difficulties at the elementary school ages." Furthermore, "children exhibiting several signs of poor adjustment had had the least amount of sickness while those who appeared to be making satisfactory adjustments had had the greatest amount of illness." These results perhaps are at variance with those we should have expected from such a study. The author offers two explanations. She suggests, first, that having to undergo unpleasant experiences such as illness can help the child to face reality in his environment; second, she feels that the attention which the child received during illness may have added to his sense of security. Another finding is of more positive value. The study showed that the children under observation had fewer problems of adjustment when they were entirely well. In other words, vigorous health is a much more important factor in conditioning desirable personality traits and attitudes than the absence of actual sickness. Dr. Walter Bauer, in an article entitled "The Changing Patterns of Motivation," which is both

amusing and profound, says, "I am ready to say that there are things more important than mere passive good health." <sup>12</sup>

On the other hand, a study of emotion and the incidence of disease by Dr. George M. Stratton suggests that frequent childhood illness may influence not only the child's attitude toward possible later illnesses, but even his emotional reactions in general.<sup>98</sup> This study showed that in a group of college students, those who had suffered serious illness before the age of six were apparently more subject to flare-ups of anger than those who had not been seriously ill before that age. However, the study does not eliminate the possibility that the patients' reactions were due as much to the attitudes of those about them at the time of illness as to the illness itself.

Since the child's actual acute illness may not in itself necessarily hold dangers for future adjustment provided recovery takes place, the nurse will realize more clearly than ever the importance of the attitudes of those surrounding the patient, for they will determine to a great extent whether his illness will create lasting emotional difficulty or will perhaps even be a helpful experience.

An understanding of the possible meaning of illness for the patient helps the nurse to evaluate the way he manages his illness as well as her own feeling about his behavior as a patient. We may make the mistake of considering the patient who uncomplainingly endures a long illness or recurrences of illness as "well adjusted" when perhaps he accepts his illness easily because he has an unconscious need for it. He may, in fact, be far more poorly adjusted than the person whose restlessness or rebellion against illness is more troublesome to the nurse. Such a situation is not unlike the classroom attitude of teachers described by E. K. Wickman <sup>103</sup> and mentioned in a previous chapter. This study showed that teachers, on the whole, at that time considered only the aggressive, obviously troublesome children as "behavior problems," while the difficulties of the shy, solitary child went unrecognized because his behavior did not force itself upon their attention.

## NURSING THE SICK CHILD

It is easier for the nurse as well as for the mother to care for an acutely sick child without becoming frightened if she remem-



bers that children over-react to pain and other stimuli. Because his nervous system is not completely developed until several years after birth, the young child is unstable as compared with an adult and has fewer inhibitory processes. The wide variation in temperature even among well children after vigorous exercise, for example, is clinical evidence of this instability. If an adult were to react in this way, a more serious condition might be implied. But the mother may not realize that such a comparison is valid until a succession of apparently terrifying illnesses which her child comes through with ease finally teaches her. The fact that the child's nervous system is relatively unstable suggests that the sick child should be guarded from noise and excitement.

During any acute illness, normal daily patterns must be set aside. It would be impossible for parents not to show anxiety and strain. Everything that will make the child comfortable or will gratify his wishes is done. It is not strange that he enjoys this new opportunity to be the center of the household and to use the new power he holds over his family and especially over his mother, who may seem to belong to him now more than she has for some time past.

It would be impossible to observe or work with children during some of the phases of their development — perhaps especially the training and the adolescent phases — and still believe the regressive old saw that childhood is a period of continuous bliss. Instead, it is clear to us that children suffer just as older human beings do. Some of the pain children undergo is mainly psychic. Some of it is mainly somatic and results from bad bumps and falls and all the major and minor accidents of childhood. Some of the physical pain is associated with illnesses, again major or minor. It is hard for adults to see a child who is in pain without trying to assure him either that the pain is not there or that something outside of himself ("the naughty door") has caused it. Or, they will try to bear the pain for him. In these ways adults may over-react to the child's pain. Thus we have the possibility that not the pain itself but the attitudes of those surrounding the child may hinder him. A pamphlet by Marian R. Genneria called *Pain: A Factor in Growth and Development*, discusses this in more detail and gives illustrative material from the author's experience. The foreword summarizes some of the content as follows:

In general adults do have the important duty of protecting children from excessive pain—pain which is beyond a child's limited equipment to deal with. It is important, therefore, for adults to realize that since pain is a natural response, children can and should be protected from it only to a limited degree. We must discriminate between painful situations from which a child must be shielded and painful situations from which he cannot be protected. More than that, we must understand from which situations we must not make an effort to protect him."

It is further pointed out that the child "grows" through finding resources for endurance within himself, up to the limit of his capacity.

The exhausted mother and the demanding small convalescent who will not allow her to go out of the house for fresh air and relaxation make a picture familiar to the nurse. The nurse has not been subjected to acute fear as has the mother and so can see the situation more clearly. She can point out to the family that routines gradually can be resumed, that new activities can be given the child so that he will begin to find interests other than his dependent clinging to his mother. If she has imagination and understands appropriate play material, she can give the family practical help by suggesting amusement for the patient which will give him the amount of activity recommended by the doctor. The child is better able to understand the period of acute illness when he is in actual pain than the convalescent period, during which his weakened condition is less obvious to him. Play can furnish a safe outlet for his growing energy and a useful road back to his usual activities. Play material may also decrease the possibility of masturbation, which sometimes accompanies the convalescence of a child who is bored and unoccupied. At first his attention span will be shorter than usual and he will require a variety of play material, which will interest him for short periods. Some of the play material should be of a kind that the child can use by himself, and, increasingly, it should require active participation by the child. The danger is that mother and friends will continue to "amuse" the patient as they did when he was capable only of passive participation. Perhaps at this time he can be given an interest in creative material that will continue when he is entirely well.

The nurse can explain to the parents that their concern over the child's symptoms should be expressed as little as possible in his

presence so that he will not prolong them to gain attention. For example, many a child has found during an illness that his vomiting creates a pleasantly complicated situation. Those present rush about and wait on him anxiously. Such a reaction on their part can be built up by the child until his slightest gag brings response from the family. This is one way in which a child learns that illness can be useful. The suggestion offered here is not the withdrawal of the family's interest and attention from the patient, but the redirection of that attention toward devising normal activities for the child as fast as his condition will allow. Two sources of danger need emphasis. Special attention may be continued longer than necessary. Or, the parents, worn out, may feel that the danger is past and, in indulging their own need for rest and relaxation, may forget the effect on the child of the sudden diversion of their interest to themselves and to everyday matters.

Other instances of "problem behavior" which have been traced to a child's experiences during illness are available: enuresis following circumcision; continued coughing; refusal of food and retention of food in the mouth following recovery from tonsillectomy; food fads and refusal of food following physician's orders that a child be forcibly fed a specified amount of food or certain kinds of food. These are instances of behavior which the child used originally to avoid pain but which he continues to use because he finds it useful in gaining his own ends — often to keep the attention he enjoyed during his illness. These attitudes in turn are important in adult life, both to health and to social adjustment.

Adults sometimes forget that the child's work and play are as important to him as their own activities are to them. In fact, they may be much more important to him because he lacks the perspective that experience may bring. A temporary illness may hold as many inherent dangers for his emotional life as does a permanent disability if these dangers go unrecognized. Partly for this reason, many communities make teachers available to shut-in children. Katherine Oettinger tells of a visiting nurse who cooperated in such a plan, and describes its effect on a small boy:

A youngster, who broke his pelvis, had been a leader in his class. He maintained friendships with the boys who visited him and gave reports of their advance in studies. This eighth grade pupil was becoming fretful,

whiny, and morose. He would not graduate with his class. Next year he would return to a "bunch of babies." His mother argued and coaxed to no avail. He lay discontentedly with his face to the wall for the greater part of the day. It is small wonder, when the visiting teacher gave him six months of instruction, that he grasped each lesson with avidity. His poorest subject, English, he passed with a mark of 94 per cent. When the boys from school came to talk with him about lessons, he was well ahead of the game. His teacher had given him supplementary books to read in almost every subject. Elated, he graduated with an average of 92 per cent. Next year he will start high school with a mended body and no warping of his personality."

The manner in which the nurse gives treatments to the patient during illness also acts as a conditioning experience, the effect of which is observable in future illnesses, in later attitudes toward health matters and toward doctors and nurses, and even in relationships with other people. The nature of certain treatments which are easily managed everyday procedures to the nurse may have a significance to the child which make them difficult for him. The emotional reaction of the patient to various nursing procedures is a subject which has not been widely studied and about which little is known. However, observation shows some quite definite reactions to the following nursing treatments.

Rectal temperatures may be ordered for infants and small children who cannot be trusted to hold a mouth thermometer safely. This simple procedure seems to be an unpleasant one, sometimes not so much to the patient as to the mother, especially to many foreign-born women. They do not understand the anatomy and physiology of the body sufficiently to know why this is done. Because the procedure is somewhat mysterious to them they often have misconceptions concerning it. For example, mothers refuse to allow the nurse to take the rectal temperature of an infant because, as they say, this has caused diarrhea on previous occasions. It is more serious when the mother's reaction against a rectal temperature as "immodest" is observed by older children or when the patient is old enough to sense that his mother sees something strange in what is happening to him. After all, when one looks at it from the child's viewpoint, taking a rectal temperature is rather a peculiar business. As a matter of fact, many a child has been punished for indulging in much the same type of behavior. We shall have to continue to take rectal temperatures. But a careful, though matter-of-fact, explanation of what the treatment is and why it is done in this way, and the use of imagi-

nation and resource to avoid a struggle with the child when the thermometer is inserted may avoid unnecessary emphasis on a part of the child's body which at that time may be especially interesting to him.

A two-year-old child was given almost daily cleansing enemas by his mother because of his constipation, which she did not know how to correct through diet. After the enemas were given, the child was held precariously over an adult toilet so that he might defecate. Probably defecations had been painful because of the child's constipated stools and the frequent enemas further contributed to the child's fear and rebellion concerning defecation. These treatments were coupled with the added fright of being insecurely seated during the uncomfortable process of returning the enema. After the nurse entered the situation, the child's diet was corrected until it was well balanced. However, the child still refused to defecate at the time he was asked to do so and showed every evidence of fear. His fear was again increased by the fact that his mother, worn out by the long struggle, spanked him for what she felt to be a willful lack of cooperation. He preferred this, however, to going to the bathroom, which had been the scene of painful incidents. Several months of reconditioning through gradual relaxation of tension on the mother's part and through use of appropriate toilet arrangements were necessary before the child lost the fear which had been exaggerated by unwise use of enemas. This actual instance, as known to a nursing organization, stops here. But it would be interesting, if one could follow this child through the illness he will inevitably have, to discover how far he has been conditioned by his early experience.

The nurse finds or has referred to her a number of little girls who have contracted gonococcal vaginitis, which necessitates obtaining a vaginal smear, first for diagnostic purposes and later as a means of determining progress. The procedure for obtaining the smear holds similar but greater possibilities for danger than that for taking the rectal temperature and, like the temperature procedure, it often means that the child must be forcibly held. Adult restraint of this kind may seem like attack to a frightened child. In addition to the use of restraint, the process in itself is difficult for the child. Clinic staffs seem to be special transgressors in failing to realize this difficulty and in attempting to hurry the child through the procedure without taking time for explana-

tion and for quiet, gentle handling. These little girls are no longer infants. In addition to the obvious factors in the situation, many of them already have had experiences which intensify the anxiety and fear frequently caused by the taking of the smear.

One nursing organization found that it was being called upon to give hypodermic treatments of various kinds to a large number of children. Sometimes the child struggled, occasionally breaking a hypodermic needle. The nurses compared notes on their experiences in giving this treatment in an attempt to improve the situation. Some children were comparatively untroubled by the injection. They cried as the medication entered the tissues, but stopped crying at once when the pain was over and were willing to be friendly with the nurse. These were children who had already learned to accept some painful occurrences as necessary. Other children reacted badly. They were very much afraid, a fear which was fed by the solicitude of the parents when they were present during the treatment. The nurses in this group started a definite attempt to make the experience a constructive rather than a destructive one for these children, with the idea that a difficult experience, successfully carried through, could be helpful rather than harmful to them. In carrying this out, the following points came up for consideration:

Is the nurse "nervous" about giving the treatment, or can she approach the situation in a way that gives the parents and child confidence and which presupposes acceptance on the part of the child?

Is she skillful, and is her equipment in perfect condition? A sharp needle and a quick, steady hand may be the means of diminishing the child's fear. The actual insertion of the needle should not be painful; the nurse may be able to teach the child that this is so.

Is the nurse alert to difficulties in the situation, such as former treatments which may have conditioned the child or the oversympathetic attitude of parents? Is she trying to solve these instead of resorting automatically to restraint of the patient?

Does the nurse try to interest the child in preparing for the treatment and perhaps persuade her to participate in this?

Can the nurse plan the visit so that it centers about a health problem rather than merely the giving of the hypodermic?

The majority of the children took the treatment with less difficulty after the nurses made a conscious attempt to help them in these ways.

The problem of giving medication by mouth is also a difficult one. The nurse may feel that this is more the patient's problem than hers. She will see to it that he is provided with the right dosage; then the patient must swallow it with what grace he can muster. The adult patient can be depended upon to do this manfully in most instances, though he, too, could often be given more help in the way of "chasers" or in the preparation of the medication. For example, the patient is sometimes given as many as six sodium bicarbonate tablets though fewer tablets of higher dosage each would ease the process for him and be equally effective. Laboratories and physicians are recognizing the advisability of making medications and treatments as painless and convenient as possible.

With patients who are children, one cannot allow the medication to be too unpleasant if it is to be taken at all and, what is as important, retained. Ingenuity is a better tool than argument in giving medicine to sick children. To have created a situation where mother and nurse, armed with pill, beg and plead at the bedside, is a minor triumph for the child and one which he naturally enjoys so much that he probably will not fail to repeat it. An understanding of the swallowing apparatus is helpful here. A nurse caring for a small patient who happened also to be somewhat mentally retarded and so still more difficult to treat, found that he had difficulty in swallowing pills because they became lost in his mouth, the sugar coating was dissolved, and the bitter taste was there in full value before the pill was even in swallowing position. She learned to place the pill on the very back of the patient's tongue where immediate swallowing was inevitable. This was not as easy as it sounds because the child had been so conditioned by the bad taste of pills which he had sucked that for some time it was difficult to persuade him to open his mouth, sometimes even in order to eat or drink.

Treatments which are pleasant and comforting, like massage and passive exercise, also hold often unrealized elements of danger because of their possible significance to the patient. Nurses who have specialized in orthopedics and who are carrying out a program of rehabilitation among "postpolio" patients express their growing realization of these dangers. They say that the child's illness often becomes the chief basis on which attention is

given him both by the nurse and by the mother. The suggestion previously made — that the visit center about a health problem rather than the giving of a treatment — may be useful in this instance too. Emphasis can also be placed on any progress the child may be making in the use of certain muscles rather than on the exercises themselves. The mother can be helped to understand how unfortunate it would be if the only time at which she gives the patient her undivided attention is during the period of exercise.

Not only the more complicated treatments, but the routine matters of feeding and bathing a sick child influence his attitude toward his illness and his social development in general. The child's habits of independence are but recently learned. He may resort readily to demands to be fed and cared for, and regression will depend on whether the steps he has been making away from infancy have been on the whole satisfying, and on the methods used in his care during illness.

The nurse's task is not an easy one in the many situations of which these are merely instances. She has a dual responsibility. In the first place, she must make sure that the medication is taken or that the treatment is adequately carried through. In the second place, it is the responsibility of the nurse to work out and use methods which will ensure that the benefits of the treatment are not counterbalanced by resulting emotional difficulties on the part of the patient.

### LONG-TERM ILLNESS

Of necessity, new concepts as to what constitutes chronic illness have been arising in recent years. At one time perhaps we visualized sick people as belonging loosely in three groups. One of these groups was composed of the temporarily acutely ill; another was made up of individuals suffering from one or another well-known disease such as tuberculosis or cardiac ailment; a third consisted of long-time, chronically ill patients sometimes with less clear-cut diagnoses. The majority of the latter seemed to us to be aged patients whose care made heavy demands upon the staff of the public health nursing agencies which did bedside nursing. It has not been easy until recent years to see this public health prob-



lem as a whole and to realize how much is now entailed in chronic illness. We now think of two large groups of ill patients—the acutely ill, and those with long-term illnesses. However, we also see the interrelatedness of these two groups and accept the necessity for prevention more realistically and with more purpose than ever before.

The following excerpts from *America's Health* state some necessary facts and interpretations in brief form. (The italics do not appear in the original.)

A basic change is required in society's transitional attitude toward chronic illness and its victims. The realization that much illness of this type can be prevented and that many persons heretofore regarded as inevitably disabled can be rehabilitated . . . must become the starting point for any genuine program of chronic-disease control. . . .

Differentiation between acute and chronic diseases is not difficult. . . . The latter are characterized essentially by their long-term nature. *Symptoms may be undetected, intermittent, or continuous.* . . . They require medical supervision or care for months, years, or even an entire lifetime.

In the National Health Survey of 1936 it was estimated that some 25 million persons in the United States are suffering from a chronic illness; more recent research has demonstrated that this figure is probably grossly underestimated. . . .

What are the most important diseases which can properly be described as having a chronic nature? Ranked in order—in terms of combined indices of prevalence, resulting disability and invalidism, and mortality—they are, heart disease, arteriosclerosis and hypertension, nervous and mental diseases, the rheumatic ailments—including arthritis, neuritis, and similar conditions—kidney diseases, tuberculosis, cancer and other tumors, diabetes, asthma and hay fever, and hernia. . . .

Public health agencies are beginning seriously to recognize the fact that chronic disease is become a major public health problem, now that many acute communicable diseases have been conquered and a greater proportion of the total population is surviving into middle and later life. It would be a grave mistake, however, if they were to attack this problem largely in terms of the need for more institutional facilities. . . . It is probably among the chronically ill persons sixty-five years of age and older that the greatest need exists for institutional care. . . . *Any attempt to solve the problem of chronic illness must be made in terms of the individual.*"

All public health nursing organizations, therefore, carry on a tremendous service for the chronically ill—if one uses the term in its vigorous current sense. Occasionally one of these patients may be bedridden for life. But commonly he is an ambulatory

patient, under the care of private physician or clinic, going to school or work, or caring for a household.

In the description of symptoms in the material quoted above, the word "undetected," among others, has been placed in italics. Perhaps the inclusion of this term in the listing means that presently we shall have more recognition of and help for that large group of persons who might be called "the ailing." In the course of our work we see many individuals who are seldom acutely ill, and yet are never really well, and whose lives and relationships are narrowed and blunted — but whether the illness is the cause or the effect of this condition is not clear. They complain of symptoms which they feel are too slight to warrant medical attention. This is perhaps especially true of our more underprivileged patients. They have little zest for living and must make an effort to carry on their work or play. Individual work with these patients, based on study of their symptoms in relation to their attitudes and manner of living, is the ultimate way in which to help them. If there were a more common understanding of their needs and a sharpening of diagnostic facilities, more rapid progress might take place with this group.

An illustration of such work with individuals is a project carried out in New York City with children of lowered vitality, reported upon early in 1947.<sup>61</sup> After experimental beginnings, a nutrition-health program was undertaken in 1941 by a health improvement class under the Board of Education, in cooperation with health service agencies. Gratifying results were reported, both with the children and with their families. Three years later, three more groups were added. In 1945-1946, sixty teachers participated in a workshop to study the findings and to plan extensions in their own communities. The data pointed up the relationship of emotional and social adjustment to physical factors, and showed that it was practicable to pool community resources in helping such children. The preparation of a study guide followed. Among the groups that helped to prepare this were: the Division of Physically Handicapped Children and the Bureau of Child Guidance of the Board of Education; the Bureau of Child Hygiene of the Department of Health; and the Division of Educational Nursing of the Community Service Society.

In thinking about the great group which constitutes "the ail-

ing," one remembers the frequently published estimate that the conditions of at least 50 per cent of the patients seen by the general practitioner have a large psychic component. This fact places a heavy responsibility on the physician in general practice, which he is endeavoring in various ways to prepare himself to meet.<sup>88</sup>

A study which seems most interesting in this connection was carried out at the Lahey Clinic in Boston by Dr. Frank N. Allan and Dr. Manuel Kaufman. A survey was made of a thousand patients at this clinic who had been given a general medical examination. The purpose was "to evaluate the importance of nervous and mental factors in relation to ill health." The "complaints" of the patients were studied in relation to the examinations. In 60 per cent of the patients these complaints were directly related to physical disorders; in 27 per cent they were "purely" psychogenic; in 13 per cent a combination of physical disorders and significant neuropsychiatric disorders required attention. Taking the last two groups and omitting those with clearly mental disorders, 32.1 per cent or 321 patients presented "benign" nervous and emotional disturbances.

For these cases of "benign" nervousness there is no diagnostic term which has been generally accepted, but they must be distinguished from the other groups in the consideration of diagnosis, treatment and prognosis. Although there is no clearcut line of differentiation, there is just as much difference from the practical standpoint . . . as between the neuroses and the psychoses. . . .

A neurosis is largely dependent on an intrinsic defect in the personality . . . and is usually considered to be an expression of subconscious emotional conflicts. There may be a background of constitutional inadequacy. In the family history "nervous breakdown" is of common incidence. Multiple complaints are usual. The history is changeable. The onset of complaints is vague—they frequently date back to childhood. Benign nervousness, on the other hand, is largely the result of external factors. The patient is of average constitution. He is more likely to have a single complaint. He gives a consistent history. He can date the onset of his symptoms, and he gives a previous history of average health.

The reaction to reassurance in these two types of cases is decidedly different. The neurotic patient is disappointed when the physician tells him that the physical examination gave negative results. He needs psychotherapy planned to suit his individual circumstances. The patient with the benign nervousness expresses satisfaction if informed that there is nothing physically wrong. He can recover without any special psychotherapy other than sufficient time with the physician to ventilate his problems.<sup>9</sup>

Nursing the chronically ill patient depends on such factors as rest, management, and diet. The term "management" means the patient's management of his life. Why does this chronically ill patient manage himself as he does? The answer to this does not lie only in difficult home conditions, to which such factors as unemployment, had housing, and lack of recreation may currently contribute. It lies also in the factors discussed here, namely, the kind of person the patient is, as partly determined by past experiences and, among them, experiences of illness.

In the matter of climbing stairs, for example, it will make a difference whether the cardiac patient is a person who does not face reality, disregards the fact of his illness, and insists not only on walking but perhaps on running up the stairs; or whether he is one who willingly follows instructions, so that he goes up and down stairs slowly and carefully and as seldom as possible. Forbidding the patient to climb stairs will not necessarily eliminate the danger of overexertion because he will carry over to other situations his way of behaving. It is the patient's reaction to home and work, not the conditions of the home or the job, which is the primary point for the nurse to observe and to report to the physician. If the nurse considers the home situation itself as the sole determinant of behavior, two sources of error enter in: first, the nurse may see conditions as tolerable or intolerable according to her own personal standards; second, her observation may be incomplete because she does not correctly estimate the patient's standards and his ability to meet his difficulties. Every individual has difficulties. It is the patient's way of meeting his particular difficulties which is important. Poverty, overcrowding, underfeeding, lack of health education are environmental factors whose harmful effect on health has been demonstrated. However, René Sand in *Health and Human Progress* states that man, not his surroundings, becomes the center of hygiene.<sup>86</sup> Public health is not only a matter for broad, general application; it also must be "individualized according to the constitution of the subject."

One wishes that more material were available on "rest" — what conditions actually indicate that the chronically ill patient should rest, what constitutes rest. Rest certainly involves more than the cessation of work or other activity.<sup>10</sup> Yet it seems apparent that public health nurses, and physicians as well, use this term loosely

in giving general advice to a patient who seems to lack vigor, from whatever cause. Most of the material on this subject discusses rest in relation to the tuberculous patient, or sleep, its nature, the amount necessary, and methods of inducing it. A brief quotation from Krause's *Rest and Other Things*, published in 1923, furnishes a useful generalization: "Instead of saying 'rest' let us say 'relief from strain.' Let us then put the matter thus — that relief from strain is any state of physical or mental activity or inactivity that does not reach the point of conscious fatigue; and by fatigue we would include ennui." <sup>88</sup>

A practical note appears in *Health and Human Progress* to the effect that rest is in general insufficient among the very poor, principally because of crowded living conditions. <sup>89</sup>

In the concluding observations of her study, *The Social Component in Medical Care*, Janet Thornton speaks more specifically of "strain." Various conditions bring about strain, which in turn results in fatigue. She points out that, while tension and fatigue may be the general result, measures for rectifying this fatigued condition must be varied to meet the situation which brought it about rather than applied in blanket fashion:

Lessening of labor is required in some instances, change or even increase of labor may be required in others. . . . A distinction emphasized is that between restless idleness and restorative rest. Rest by limitation or modification of activity was a frequent and important prescription which many patients found difficult and many failed to observe. The influence of social factors in preventing rest was repeatedly observed. Indeed it is our impression that in relation to no other medical therapy did social factors appear to have as much importance. Our findings indicate that study and experiment are required to render the rest therapy a more reliable measure. <sup>90</sup>

"Social factors" include here not only the conditions which the individual is laboring to meet, but his individual reactions to such conditions, and to inner conflicts.

The chronically ill include those who suffer from frequent recurrences of illness. Psychiatrists offer several observations on the relationship between the emotional and the physical in these recurrences. Organic disease may be so concealed by psychic symptoms as to have been unrecognized in a previous examination. Or the psychic causation of the illness may persist and bring the patient again to the point where functional disturbances cause

recognizable damage. Or the patient may unconsciously need this illness as a way out of unbearable conflict, which he himself may not even be aware of or which he may not be able to meet in other ways. Operations and treatments of a radical nature sometimes complete the breakdown of the individual in such instances because the illness was a means of defense. The possibility of such a reaction is increasingly taken into consideration before a decision to operate is made. The nurse who cares for such a patient postoperatively needs to be aware of this factor. Since the patient himself may not know what is troubling him — may, in fact, often deny when questioned directly that he has “anything on his mind” — the observations of the nurse as she sees him in his own home can be invaluable in helping the physician to understand him. Not all physicians want this help from the nurse; but increasing numbers welcome it when the observations reported have a definite bearing on the patient’s symptomatic behavior.

The broader concept that in chronic illness, as in all illness, social and psychological factors are involved carries with it also a broader concept of convalescence. Recovery from a current physical disability is not enough. Successful convalescence also implies that the patient has become able to meet and solve his problems, or work along with them at least to the point where they cease to disable him.

Emotional reactions to certain chronic illnesses such as tuberculosis and cardiac disease have been observed. These reactions vary, especially in their degree, with the personality make-up of the individual patient but can be discussed together because of the similarity of the situation created by illnesses of a long-term, chronic nature.

For a long time it was accepted by many of us that tuberculous patients in general were cheerful and optimistic in their attitude toward their illness. This seemed to be the case in past years when diagnosis was usually not made till the disease had reached an advanced stage. Modern case-finding methods were not in use and early cases of tuberculosis went undiscovered. The patient with advanced tuberculosis shows a courageous, optimistic attitude, either because he refuses to recognize the reality of what is imminent or because, facing death, he is indeed courageous in this extremity. Now that tuberculosis is frequently discovered in its

early stages, the patient faces a long-term, incapacitating disease and confining treatment. The illness alters his way of living and may make him a menace to those he loves best. Faced with such a situation, often without being acutely ill, the tuberculous patient reacts not with desperate courage but as he would react to any threatening experience of such magnitude — with fear, with doubt and unhappiness, with depression and rebellion, in degrees characteristic of him as an individual.

The long-term element in tuberculosis contributes at the outset to the difficulty of accepting the diagnosis. This can be seen at the time the diagnosis is made, according to Dr. Andrew Morland, a London physician who has observed many tuberculous patients.<sup>73</sup> He states that when the onset of the disease is dramatic and incontrovertible, steady progress toward recovery often is made by the patient. With less evidence of disease, however, the attitude of the patient may be incredulous. He will take any loophole for disputing the diagnosis and refuses to face the months of treatment that are necessary for recovery. If, as the writer comments, a friend has been diagnosed as tuberculous, the patient is willing to admit that the friend will be ill for a long time. But the patient himself, even when convinced of his diagnosis, feels sure he will be cured in three months.

The long duration of the disease affects the attitude of the patient toward treatments. One would think, comments Dr. Morland, that it would be a simple matter to carry out a regimen of rest, fresh air, and good food. He states, however, that many tuberculous patients have not the psychological endurance to carry out this regimen for a sufficient period. In summarizing his material Dr. Morland says:

Specific remedies are no more than adjuvants to general hygienic treatment aimed at "raising the resistance." In this struggle between health and disease the mind plays an important part, and I believe that further understanding of the mechanisms by which the mind responds to the stimulus of the disease would enable more rational and effective treatment to be applied

Awareness of these factors in a long-term program helps the nurse to keep her own as well as her patient's interest alive during the months and often the years that she must spend in supervision and encouragement.

Three of the "mechanisms by which the mind responds to the stimulus of disease" — fear, regression, added egocentricity — have been considered earlier in connection with the acutely ill patient. They apply here also.

That people in general are afraid of tuberculosis was noted previously in commenting on the attitudes of nurses who are caring for patients with communicable disease. Dr. E. P. Bledsoe, who has had long experience with tuberculous patients and whose book, *The Psychology of the Tuberculous Patient*, has already been mentioned, gives the "fear complex" as the basis of most of the psychological disturbance which he sees in tuberculous patients.<sup>15</sup> A fear of death, of disability, of the hospital, frequently not admitted by the patient or recognized by him, remains as a continual source of this complex. It is necessary to realize in this connection that the acuteness of the patient's fear is not necessarily proportionate to the amount of pathology evidenced in his lungs. Frequently the patient who shows most psychological disturbance is the one who has the least tissue damage.

Recognition of fear on the part of the tuberculous patient is important to the work of the nurse not only as she gives bedside care, but also as she may urge the hospitalization which has been recommended. With this in mind she will not hurry the patient's decision to be hospitalized and she will make sure that she has explained the steps preliminary to entering the hospital and the hospital routine he may expect, in a way that he can understand. The nurse does not need to wait until the patient has expressed his dread of sanatorium care in so many words before attempting to meet his emotional difficulty. She can "talk to" and often relieve the unexpressed fear that she knows may well underlie his behavior. She can say in the course of conversation that many persons are afraid to go to the sanatorium because they feel it is a step which separates them for the time being from their families; because they do not know what to expect from such hospitalization. Seeing that the nurse understands his feelings in the matter, in addition to understanding the disease process, the patient may develop confidence in the treatment she is suggesting.

Occasionally a patient has an excellent reason for refusing sanatorium care which he may be unwilling to express to nurse or physician. Such a situation came to light in the case of one



patient when she finally explained to a visiting nurse that she felt she could not leave home because her husband would then be able to spend all his time with another woman in whom she knew him to be interested. For several months, however, in talking with the nurse, she had based her refusal of institutional care on fear of hospitals. Finally, her slowly growing confidence in the nurse enabled her to express her real reason for refusal. Other reality situations are equally deterrent to treatment in the mind of the patient.

In one community, where sanatoria are taxed beyond capacity so that there are long waiting lists, the period of waiting adds to the difficulty of hospitalizing patients. During the long wait for admission the patient begins to feel that the drastic step of hospitalization may not be necessary after all, since he is getting along somehow without it. His interest is often seriously deflated and his old fear of treatment away from home is revived.

The patient's relationships with his family and his social relationships in general are threatened by his fear of this illness. The possibility that he will have to be separated from his family is in itself difficult enough. It is still more difficult to face his family's fear of contracting tuberculosis, which must seem something of a personal rejection. The following is taken from a nurse's record:

*The father of this family is at home from the sanatorium for a visit with his family. The mother has been very tense and nervous since the father has been at home. She fears that he will infect the children. She keeps the children away from him as much as possible and shows her own fear also. The father told the nurse that his family no longer love him or want him around.*

Perhaps the mother's attitude toward the father is not based entirely on his tuberculous condition. Unconsciously, she may find his illness convenient if she no longer loves him. If this is true, there is not much the nurse can do to relieve the situation. If, however, the mother does not realize that the sanatorium would not have allowed the patient to return home if his condition were such as to endanger the family, provided simple precautions are taken, and if she does not know how to employ these simple means of safeguarding members of the family from infection, then the nurse can be of service by making these matters clear. Furthermore, she can show how these safeguards can be introduced into family routine with as little emphasis as possible so that the

patient will not feel he is a burden or too different from other members of his family.

In many instances the patient's fear of the disease is augmented by fear that he has already caused harm to others, and he refuses to face an examination that may verify this suspicion. For example, a six-year-old child was diagnosed as having primary tuberculosis. This little girl was the only child in the family and was idolized by her father. Her mother and all other possible sources of infection except her father had been examined and found negative to tuberculosis. This left the father as the possible source. He stated that if it really was he who had given tuberculosis to his daughter, he never wanted to know it and steadily refused examination. His attitude was perhaps strengthened by the fact that as a baby he had contracted poliomyelitis, which left him with a useless left arm, indicating, to his mind, that doctors are inadequate people anyway. Here the emotional residue of a childhood illness made a disastrous appearance in adult life and complicated the difficult relationships in which fear of tuberculosis may involve an individual.

Children who have tuberculosis do not escape this fear or its attendant feeling that because of their illness they are to be cut off from their families and friends. A fourteen-year-old boy had been excluded from school because of an adult form of tuberculosis and was awaiting admission to the sanatorium. Meanwhile none of his former friends would play with him. His mother cried "all the time." The boy was running wild, committing minor thefts, and threatening to jump in the river in a frenzy of rebellion based on fear. Another boy of eleven was reported to a visiting nurse association as refusing to play with other children. This child had a primary form of tuberculosis which was not communicable to others. However, his family had so frightened him and so impressed upon him the dangerousness of his condition by constant emphasis on it at home that he considered himself a pariah. The nurse was able to right the difficulty by an explanation to his parents, who were amazed to think that the boy had taken their remarks so seriously. The nurse recognized also that this child had gained a certain amount of satisfaction from the distinction of having, as he thought, a desperate illness which set him apart from others — an unfortunate way of gaining attention.

A previous quotation suggested that the patient would try to find every loophole for escaping a diagnosis of tuberculosis. Refusal to be examined, broken appointments for examination, seeking favorable diagnoses from "voodoo" doctors and other quacks are some of the common escapes from actual diagnosis which the nurse finds it difficult to meet. There is no short cut to helping these patients. Certainly mere insistence on examination will often add to the patient's resistance instead of bringing him to a physician. One can, however, recognize that the emotional basis for this resistance is often fear, expressing itself through a variety of behavior on the part of the patient and his family. Continued visiting by the nurse when the patient will allow this, appreciation of the fear underlying his apparent lack of cooperation, a genuine interest in helping patient and family to work out the situation rather than the attitude that hospitalization or prescribed treatment is a stint to be accomplished, may lead the patient to have enough faith in what the nurse represents to offset his fear.

Among tuberculous patients, a tendency to regression is often related to the type of care necessary — complete rest and the elimination of anxieties and responsibilities. The patient is unceasingly guarded by nurses and doctors who arrange routine and supply food, fresh air, and sunshine as they would for a child. In the old days, insistence on more than a quart of milk a day provided an infantile diet which probably still further symbolized a return to childhood. The patient may reach a point where he is entirely happy and secure in the "queer sheltered world" which hospitalization offers him.

The following instance, taken from a nursing record, illustrates this regression. A young man who had been in a sanatorium for three years behaved in a regressive way when he returned home. Home conditions heightened rather than relieved his desire for dependency. He had first gone to the sanatorium shortly after graduation from high school, before he had learned a trade or become interested in any occupation. His parents were dead and his sister, who maintained the home, was not interested in him and even resented his presence. Even under such circumstances, with the fair degree of health this boy possessed on discharge from the sanatorium, some young men would have found a room elsewhere and looked for work. This patient refused work and refused the

clinic and the nursing supervision that might have helped him to find his feet. He deliberately exposed himself to bad weather and refused to eat until his condition became so precarious that he had to return to the sanatorium. To get back into the hospital where he had constant care and attention and no responsibilities was the purpose of this behavior, as he himself stated.

The egocentricity which characterizes all sick people is frequently exaggerated to some extent by the nature of tuberculosis, which concentrates the patient's attention on himself over a long period and at the same time cuts him off from his usual activities and companions. It has been aptly said that tuberculosis frequently becomes the patient's career. He may spend his days taking his temperature and noting his physical reactions. This behavior is a danger signal, suggesting not so much the need to take away the thermometer as the need to give the patient fresh interests. The energy engendered by his emotional reaction to his long-term illness must find release in activity of some kind or it will merely be destructive.

Although the fact is stressed throughout these pages that it is the patient we are nursing, not the disease, cardiac disease, like tuberculosis, needs mention here because it is a condition which, even more than tuberculosis, is shown by research to be a specific source of fear and anxiety. The statement has been made that the heart is the only organ which, diseased, can cause not only pain but anxiety. This anxiety is a direct reaction to organic condition, not a reaction chiefly conditioned, as in tuberculosis, by the possibility of a disrupted life. Consciousness that the heart is not functioning as it should in itself brings fear. Furthermore, anxiety can create a functional heart condition which may incapacitate the individual just as truly as organic impairment. Constant anxiety, expressing itself in a functional heart condition, can also bring about organic heart disease. This is a difficult kind of vicious circle which the physician is called upon to understand and diagnose in all its complexity. Environmental conditions leading to anxiety often can be observed by the nurse. She may also observe a chronically anxious state on the part of the patient when circumstances do not appear to warrant it. Anxiety unrelated to the environment suggests a need for treatment by a psychiatrist, in the hope of averting still more serious illness, functional or even organic.

One of the facts brought out by research — most important for public health nurses to understand in this connection — is that the patient's subjective feelings may not give a true picture of the severity of his disease. This makes it particularly important that the nurse should work closely with the physician who recommends a regimen to a patient. The nurse will know the physician's diagnosis and his exact recommendations, but she must also be sure to report the patient's activities to the physician. Patients with serious organic damage have a tendency to make light of their symptoms and lack insight into the seriousness of their condition. In contrast to this, the patient whose cardiac symptoms are a neurotic outlet experiences symptoms even though the physical findings are negative. We have sometimes thought that cardiac patients who refused to take necessary precautions were over-courageous, perhaps stubborn. As a matter of fact, their attitude often shows a dangerous inability to understand the real situation. For the most part, their own judgment of their ability to work is dangerously optimistic as compared with that of the physician, which is based on actual findings. Nurses who see patients conducting their daily lives should know the significance of these psychic reactions with regard to cardiac disease, frequently an enemy in disguise.

Third, and finally, in this sampling of chronically ill patients, the patient with a malignancy should be mentioned. The literature does not offer us as yet any wealth of material describing or clarifying the emotional aspects of malignancy. Perhaps the fear associated with this condition is too clear to need emphasis. Experience suggests, however, that the answers to two questions are especially sought whenever cancer is discussed in professional groups. To the first question, whether or not it is justifiable to arouse fear among people in general in order to increase the number of early diagnoses, a partial answer is the fact that early diagnosis can be followed by successful therapy. A second question is still unanswered: If, when, and how should these patients be informed of their condition? One wonders whether this comment, based on experience, is accurate — namely that this decision currently seems to vary with the physician and does not depend entirely on the situation and personality make-up of the patient.

Even though we use the concept of chronicity in the broader sense that has been discussed here, we shall still have the hed-

ridden patient whose illness was not, or perhaps could not be, prevented. The nurse may be the only person who comes to the home primarily to visit the patient. As the years go on and his condition is little altered, family life inevitably divides and flows around him, leaving him stranded, so that there is only a small part of the family activities that he can call his own. The nurse, however, comes to see *him*, and in doing so makes him feel that he still has some recognition as a person. "Busy work" may be helpful for such patients. But if occupational therapy in its real sense is to fill some of the patient's deep need, the activities given him must be more than a pastime. If, for example, a patient works in leather or with other tools, an opportunity to sell or dispose of what he makes doubles the value of the activity. If a patient knits a sweater, she should be aware as she knits that someone needs the sweater and is looking forward to receiving it.

In addition to giving the chronically ill patient this satisfaction, the fact that the nurse lifts some of the burden of care from members of the family may benefit family relationships. Even in families where the invalid is a loved and welcome person, the demands of continuous care, the added financial burden, giving the patient a room by himself, keeping children quiet, entertaining under difficult circumstances, are a strain on family life. The nurse contributes to happy relationships in that home — directly, through relief of those who would have had to give the care otherwise and whose conscious or unconscious irritation therefore is lessened, and indirectly because the patient realizes that, for the time being, he is not a burden on those around him. This is one of the reasons why nursing organizations might accept responsibility for the bedside care of chronically ill patients in spite of the fact that this service is known to be expensive and time consuming.

#### DISABILITIES OTHER THAN ILLNESS

The material that follows discusses the work of the nurse with children and adults who have physical disabilities other than illness, for example, those resulting from injuries or constitutional anomalies. Our experiences during and after the second World War have shown us how adequate the many injured individuals in our families and communities may be. Perhaps we, ourselves, have been injured but remain "whole."

Nevertheless, many physically handicapped people have a difficult time — and not only because of the hampering nature of the disability. In the introduction to a symposium on the social psychology of physical disability in *The Journal of Social Issues*, Dr. Lee Meyerson, the editor, points out that we cannot get very far in understanding this problem if we consider it only from the physical standpoint.<sup>70</sup> He discusses the "negative values" of physical disabilities and suggests that these negative values can be considered in three ways.

First, society itself may impose such values because of commonly accepted ideas as to what constitutes beauty or fine physique. Or, society may have developed a classification which links a "type" of personality with a certain disability. The article says, "The movies and comics, for example, learned early that one of the easiest ways to characterize an adult as a villain was to cripple him."

Second, the atypical person has his own standards of physique, partly determined by the way the majority of people in his culture regard persons with his handicap. He devaluates himself because he accepts the majority point of view, even though its judgment is directed against himself. If this attitude persists and grows, he may become "handicapped all over" rather than merely handicapped in a particular way.

Third, the disability may prevent the individual from accomplishing easily, or perhaps at all, many of the things that the majority of people do simply and casually. "The blind person does not experience failure because pictorial art is missing from his life, but because he has great difficulty in the simple task, hardly attended to by the majority, of moving from one place to another."<sup>70</sup>

If the individual has a major disability in the sense that it hampers him greatly from carrying out the simple patterns of life, he sometimes can meet the demands of the social situation easily, sometimes only with more or less conspicuous difficulty. He is then struggling with what have been described as "overlapping" situations.<sup>9</sup> This adjective has been applied to the situation of the adolescent who, part child, part adult, constantly meets situations to which he must react either as a child or as an adult. Sometimes these have been described as borderline situations — in the case of the tuberculous patient, a borderline area between

the adjustment of the disabled child. 5. The school must consider its special program as developmental as well as remedial. 6. The school must not attempt to shift the total responsibility for the disabled child to the special teachers and the clinical services provided.<sup>70</sup>

Studies made by the Federal Office of Vocational Rehabilitation have described the successful employment, in other than "made" jobs, of amputees, the blind, persons with arrested tuberculosis, epileptics, and the hard of hearing.<sup>71</sup> It begins to seem clear that under appropriate employment conditions, such as should exist for any employed person, the worker with a disability performs as well as the undiseased worker — and perhaps with more reliability.

We are increasingly aware that the home or other social situation of any worker influences his safety on the job and that industry is attempting to remove obvious hazards to safety including overfatigue of the worker. However, here too it has been shown that the personality of the individual worker must be recognized as a factor as well as his physical environment. Dr. Philip Moorad, in speaking to the Connecticut Safety Society in 1947, said that statistics show that only 10 to 15 per cent of industrial accidents are now due to mechanical and environmental factors.<sup>72</sup> The remainder must be blamed on the "so-called human factors," among which are numbered neurological disorders. He suggests that a program of more careful physical examination by industrial physicians would help to prevent accidents resulting from central nervous system lesions; cerebral arteriosclerosis; peripheral neuritis, whether due to alcohol, poison, or virus or bacterial infection, or as part of a dietary deficiency; multiple sclerosis; Parkinson's disease; and other degenerative diseases of the nervous system "more common than realized." He suggests that epilepsy is unduly stressed as a cause of industrial accident, and that the "known and controlled epileptic is a safer worker than an undetermined average worker." This article also contains a helpful comparison of industrial accidents among younger and older workers. Accidents among the former are more frequent but of comparatively minor severity. Dr. Moorad classifies workers according to the risk of possible injury in the order of increasing hazard, as follows: the healthy worker without physical or emotional disorder; the disabled workman without mental or



emotional "disease"; the healthy man with mental and emotional problems (described as a poor risk); the disabled worker with mental and emotional "disease."

The concept of the accident-prone individual is increasingly familiar to us.<sup>2</sup> We understand that certain individuals are prone to have more accidents, not because they are merely clumsy or absent-minded, but because of a defect in the whole structure of their personality. Some of the unconscious conflict behind such accidents is described as a deep resentment against authority based on rebellion against rigid training methods in childhood and coupled with the kind of strict conscience that does not permit the individual to rebel openly. Since long-term psychiatric treatment is needed for the accident-prone individual, he perhaps should be removed from occupations which endanger him or the public. This would safeguard fellow employees and the interests of the employer, but it would remove only part of the difficulty, since such individuals are prone to accidents not only at work but in any situation.

Some comparatively minor disabilities — conditions which we as nurses have been accustomed to call "defects" and for which correction can be sought — sometimes have far-reaching effects. That they are not acquired dramatically sometimes masks their importance even to the individual who has them.

Parents are sometimes slow to correct their children's physical defects, not because they are poor or uninformed but because they themselves have physical defects which have long gone uncorrected. On the other hand, many parents see to it that their children's defective teeth, for example, are corrected to spare the children the pain and embarrassment the parents themselves may be enduring. But of the many who do not show this interest, some may be indirectly expressing their feeling of futility and resentment at their own condition. There is something wrong with a nursing program which can advise a father with not a tooth in his head to have the dentist put fillings in his small son's temporary teeth.

Medical aid for adult physical defects still shows some inconsistencies. For example, money may be available to support a clinic which will see week after week a patient who complains of "indigestion" but no money may be forthcoming to purchase the

source.

A family consisting of parents and five children was receiving partial financial aid to supplement the father's temporarily irregular work. The parents were in their thirties. The best part of their lives together seemed to be over. They quarreled and were unable to manage their children. The father told the nurse that he did not know what the matter could be with his wife; she did not seem to be the same person he had married. During talks with the mother, the nurse saw that one source of difficulty was the condition of the mother's mouth. She had very few teeth left. Teeth and gums were in a diseased condition so that suppurative material drained into the mouth and was swallowed. The usual odor of suppuration was noticeable, even at a considerable distance. When the nurse suggested that the mother needed dental care, the patient said she could not lose her few remaining teeth because she had no way of securing dental plates. Total extraction had been advised, but she had not returned to the clinic because she could not follow the recommendations. In this instance a public relief agency was persuaded to depart from precedent and supply dental plates, and renewed health for the mother and a very real improvement in family relationships resulted. It would be an oversimplification to suggest that all the troubles in this family were due to the mother's dental condition. However, there were strengths in this family; and by correcting an obvious defect, a threat to its stability was removed.

Here, and earlier in this chapter, one sees the influence of the illness or disability of one member of the family on all the other members. Sometimes one feels a need for renewed vitality in our accepted credo that the family is our "unit of work." Such vitality in family health work is shown us in the report of the Peckham Experiment, a club in a residential district of London which offers health and recreational resources for the whole family.<sup>80</sup> Membership is only by family groups. There a family makes friends and takes up interests as it wishes and with no organized direction, and seems to find itself, as a family, in a way that reactivates or even establishes the strength of family relationships. As part of their common interest, the families avail themselves readily and naturally of the annual "over-haul," which is the only

activity required of club members. They are interested in antepartum care and many, on their own initiative, make good use of medical recommendations.

### CHILDREN WITH CONGENITAL PHYSICAL DISABILITIES

Of the many instances of serious congenital physical disability described in nursing records, some show the patient making a satisfactory adjustment at the time the nurse first knows the situation. In one such case, the left hand and half the arm of a little girl six years old were lacking at birth. As far as the nurse can observe, she is a happy child with entirely normal activities. She rides a small bicycle fearlessly and enters into the games of the neighborhood children.

In contrast to this child is a ten-year-old schoolboy who was also born without a left hand. He is sulky and uninterested at school although he is intelligent enough to do the work of his grade. At home he is babyish and rebellious. He refuses to play with neighborhood children. In this instance the child's mother has shown her unhappiness over his condition by talking about it constantly and by giving him more help than is necessary. The nurse has noticed that he expects special consideration from children on the street.

One has great admiration for the courage of the first child's parents; and understanding and sympathy for the failure of the second child's father and mother to meet wisely the problem of his training. Instinctively, any one of us stretches out an all-too-willing hand to help a handicapped child struggling to accomplish a task one could do so easily for him. The parents of such a child have not only this natural desire to help him; they also have a *need* to help him as a means of relieving the feeling that his congenital defect is somehow their fault. Therefore the nurse in such circumstances has a twofold task. At the same time that she helps to plan and carry out the care of the child, she must keep constantly in mind the attitude of the parents toward his defective condition. In this way she may partially relieve some of their anxiety so that it need not find outlet in unwise methods that will create habits of dependency and invalidism in the child.<sup>96</sup>

Some successful new attempts are being made to increase the resources available for the education and training of children with permanent disabilities. In 1946 and 1947 institutes were conducted for the mothers of blind preschool children at the State School for the Blind at Jacksonville, Illinois.<sup>24</sup> The mothers brought their children with them to the session. Twenty to thirty mothers attended each institute and found the help so valuable that plans for an annual institute developed. The report states that parents of blind children face two recognizable problems. One is their fear of blindness as a condition and their fear of the blind person. This is described as diminishing with familiarity. The second problem is the parents' bewilderment as to how they can lighten the child's burden, especially as they begin to try to teach the child and realize how much less he can learn by imitation than other children.

Among other congenital defects frequently seen by the nurse are hernia, spina bifida, cleft palate and harelip, clubfoot, and evidence of birth injury. If the nurse gives infant care to such babies in the weeks following delivery or enters the home during the first few months of the child's life, she can help the parents in several ways to adjust to the fact that the baby has a handicap — temporary or permanent as the case may be — and to plan as normal a life as possible for him.

It is difficult enough for some parents to care for a newborn baby when he is sound and well — to know how to hold him and what to expect from him, especially if he is their first child. How terrifying to them then, if the baby has a disability which makes him even more difficult to handle and which frightens them for the future. By her skill and self-confidence when bathing, dressing, and caring for the baby, the nurse not only demonstrates good methods of carrying out necessary daily procedures, she also shows that they can be done calmly and safely. Gradually the parents will gain enough confidence to be able to handle the baby in spite of his condition. They will learn to avoid clumsiness and muscle tension, which would frighten him and thus increase their own fear.

Just how serious the baby's condition is may be puzzling to the parents, who perhaps have only partially understood the physician's explanation or have misinterpreted it. In clearing up these

misapprehensions it is not enough for the nurse to obtain the physician's diagnosis of the child's condition and his consent that she work in this home. She will also want to know as precisely and in as much detail as the nature of the defect will allow what the prognosis is, what the physician's plans are for future treatment, and how infant care should be modified to meet the special needs of this baby. For example, since a slight umbilical hernia may respond without difficulty to strapping, the nurse can easily relieve the parents' anxiety on this score. On the other hand, the baby who has a serious hernia or a spina bifida must be operated upon at some time in the future. Serious conditions like these are unfamiliar and frightening to the parents. They want to know when the operation can take place<sup>39</sup> and meanwhile need the reassurance of knowing to what extent their baby is like other children. If the baby has a cleft palate, the nurse must know when the surgeon expects to correct it, and meanwhile exactly how the child shall be fed, not only in order to aid his own development but also to relieve the parents' intense fear of the feeding process. This fear, when communicated to the baby, is fertile soil for a future feeding difficulty that is liable to persist after the cleft palate has been successfully operated upon. Giving special care only in so far as the baby's physical defect demands it may be the basis for normal life later on, unspoiled by oversolicitousness on the part of the parents.

The adjustment of the baby's care to his actual condition cannot be static but must change as the baby develops if he is not to become overdependent. To this end the nurse learns from the physician how the physical defect will affect rate of development and methods of training. She will need to know when the baby can be allowed to sit up; how much exercise he can be given; when weaning or toilet training can be started. Occasionally we make the mistake of relying on the mother's interpretation of the doctor's recommendations and find out later that it was more reliable as an index to her own fears for the child than to the doctor's intentions.

In many instances, peculiarities of appearance are congenital in origin. Often it is the parents who are sensitive about these peculiarities rather than the child, although he, too, will become

For example, a boy five years old had an oddly shaped head, narrow and unusually long from front to back. His mother's way of concealing what to her amounted to a deformity was to keep the boy's hair in long curls. The child suffered much more from the taunts of playmates about his curls than he probably would have from the slight deformity they concealed. Finally he flatly refused to enter kindergarten when his mother attempted to enroll him. At the nurse's suggestion, his mother had the child's hair cut, much to his relief and to the joy of his father. He then was quite willing to enter school, more pleased with his masculine haircut than troubled by the malformation of his head.

Again, one would not wish to minimize the suffering of parents in these situations, some of which are so serious that they cannot be met merely with encouragement and advice. The following instance illustrates the point that not only is the possible rate of development of the handicapped child a subject for the nurse to study, but also the development of the parents' ability to accept the inevitable and to make the most of any existing assets.

A six-year-old child, known for some years to a nursing agency, was a tragic little figure. This child was a dwarf. In size he approximated a child barely three years old, though his mental development was adequate for his age. He played happily with his older brother who was devoted to him, and was loved by everyone in the neighborhood. The time finally came when his mother, with great difficulty, began to face the fact that he was old enough to go to school and that he would have to be exposed to persons less understanding than his friends and neighbors if he was ever to leave the protection of home. It was a hard decision to make, and more difficult to carry out. At the request of the mother, the nurse explained the situation to the school principal, saying that the mother planned to come to school herself later for an interview. It was a full year before the mother followed this up and the child was enrolled in kindergarten. During this period the nurse did not urge the mother to quicker action because she realized that in these months the fears of the parents were being worked through to a point where the next step became possible. With the way already cleared for them as far as it could be cleared by another person, they must take their own time in reaching a state of mind that would make action possible.

Parents' attitudes toward a child with physical disability, especially one who is congenitally defective, may be complex. The more serious and obvious the condition, the more complex these attitudes may become. Similarly, the greater may be the need of the parents to hide from themselves and others some of their reactions to the child. Since parents in general feel that they should love their children and perhaps should feel and express even greater tenderness toward a handicapped child, the need to conceal, for example, a rejection of such a child becomes proportionately intense. One can understand, however, that parents, like others associated with a grossly defective child, may have at times some feeling of repugnance toward him. More than this, as has been suggested previously, to have produced a child who is not normal in all respects may be a threat to the self-esteem of any individual. If the parent's own physical condition is such that he feels it to have a bearing on the child's defect, whether or not this is actually the case, this threat is increased. If the mother has attempted to bring about an abortion, her peace of mind is further threatened. In some instances the reaction becomes in varying degrees a rejection of the child himself rather than the even more painful self-depreciation. This rejection may not represent all that the parent feels for the child. He may also love him. However, it may explain some of the methods parents use in caring for physically defective children. The nurse sees instances of this though she may not always recognize the source of the difficulty, since the rejection rarely appears in its own guise. For example, extreme oversolicitude on the part of parents may mask a rejection often unrealized by those most concerned.

The following instance shows a marked rejection by parents of a child who had sustained a serious birth injury. These parents were well able to care for their spastic child although meeting his needs would have meant some financial sacrifice as well as inconvenience. He had been hospitalized at heavy cost to the community for two years following his birth. Then physicians as well as the social workers at the hospital decided that the child could be returned to his home if a public health nurse assisted in caring for him. They agreed later, however, that their evaluation of the situation had been wrong. The nurse found that any service she could give the child was welcomed but that the family themselves

neglected him, failing to carry out the orders left by the physician and protesting that the hospital or other community resources should continue caring for him. To the nurse, whose own feeling in the matter was that the parents had a "duty" toward this child, their insistence on help from the community appeared as a wish to be dependent rather than as masked rejection of the patient. She urged the helplessness of the patient and again and again painstakingly showed the family how to care for him. After some months, however, she realized that their demands meant not so much that they wanted help as that they did not want the child. She then faced her own reaction to such rejection which, understandably, was an almost punitive desire somehow to force these parents to accept their responsibility. Finally, however, she realized that the rejection of the patient by his family was a real and urgent reason for placing him elsewhere, even though the parents thereby escaped the responsibility that many felt should be theirs. Placement was effected and resulted in marked physical and mental improvement in the child.

Obviously, many children suffer acutely from handicaps that make them look different from other children and cut them off from normal activities once they are in a position to compare themselves with other children. The special needs of the spastic child as he reaches adolescence have been emphasized in an article appearing in *The Crippled Child*.<sup>64</sup> A study made of the attitudes of crippled girls showed, on the basis of answers to certain questions, that they were more neurotic than "normal" girls.<sup>65</sup> The girls with this physical disability were more impulsive, cried more easily, were more often conscious of loneliness, did not like to be watched, and worried longer over humiliating experiences than children without this handicap. It was also shown that the greater the handicap and the older the girl, the more neurotic was her response.

This difference from others is due to the handicap itself and also in many instances to the use of temporarily or permanently needed orthopedic devices for correction, from an extra lift in the heel of a shoe to a heavy brace or crutches. The attention created by the apparatus he wears or by the treatments he is given may be an unhealthy source of satisfaction to the child. Equally unhealthy is the feeling that he is hopelessly different from other



children and that corrective aids make him conspicuous and further emphasize his condition. They do add to the "visibility" of the disability, previously discussed. Thus one has the ironic situation that the very device that enables the child to get about in anything approaching normal fashion may itself create an additional emotional problem.

Children sometimes can be rescued from very grave situations of this nature, as witness a group of "tube cases" in a New York City hospital. The lives of these children had been saved by tracheotomy. After convalescence the children were well and back to normal condition except for the fact that they continued to breathe through tubes that had to be kept from getting clogged. These children remained in the hospital, were treated as invalids, and consequently could do little for themselves. A physician coming new to the situation realized that many of these patients were unnecessarily invalidated. He taught them to be more self-reliant—to climb onto the table when their tubes were to be cared for, then to care for their own tubes. As a result, some of them became able to return to their own homes and to a life which approached the normal, even though their physical defect had in no way improved.

Study of the needs of the individual child can also lessen the harm which unnecessarily conspicuous apparatus causes in his emotional life. The following instance shows how greatly parents may need help in problems of this kind, help which the nurse is especially qualified to give. A boy of eight had a prolapsed rectum and a bladder that formed outside of his body cavity, over which he had little control. An operation was to be performed in the future. Meanwhile bulky dressings had to be constantly in place. The mother referred to these dressings as "diapers" and dressed the tall eight-year-old in sun suits that could be easily washed and that allowed access to the dressing. As a result of his mother's lack of imagination, the child was ridiculed by playmates until he dreaded the company of other children. He was also humiliated by the contrast between his own ludicrously babyish clothes and the small-boy trousers and shirt of a younger brother, who was outdistancing him in his adjustment to other persons even more than the difficult situation necessitated. The nurse who visited this home, through her skill in arranging dressings as well as

through her realization of the harm the child was suffering, helped the mother to dress and to protect him more appropriately.

We realize that a child must be helped to understand the degree of his disability and, if possible, to accept it so that he will learn to do as much as he can safely undertake and not engage in activities that will harm him. For the most part the day-by-day life of the child and of those who live it with him will teach him how far he can go and where he must stop. However, parents and other appropriate persons, sometimes the nurse, will need to help the child to understand the specific limitations of his disability. Members of the staff of a convalescent home for children with cardiac impairment, to which children are discharged when they are able to be ambulatory for a few hours each day, have reported on their way of interpreting to the individual child and on the way the home is organized to assist in this.<sup>65</sup> The report brings out the necessity of explaining clearly to the child, while at the same time being careful not to frighten him, and describes the anxiety he feels when he only partially understands his condition. The conversation of two children, eight and nine years old, who were playing "hospital" with dolls is quoted:

Mollie: Does your baby know how sick she is?

Nancy: Of course not. We never tell her that.

Mollie: It doesn't matter what we say in front of these babies. Babies don't understand.

## »» PART II ««

### *Mental Defect and Mental Illness As Seen by the Public Health Nurse*

Mental deviations from "the normal" as the nurse frequently sees them in the community are discussed in this section. The treatment of this material as a separate section may be misleading, adding to the feeling of many of us that mental abnormality in itself sets the individual apart from the rest of mankind. We know, however, that such deviations are merely a matter of degree. The problems of the mentally abnormal are discussed here primarily because experience in working with these individuals has not always been included in the education of all nurses.

Too many of the nursing schools that offered theoretical courses in psychiatric nursing gave little or no opportunity for observation of, or work with, the mentally ill or intellectually abnormal. Without this practical application, the theory vanishes from the nurse's mind or, learned by rote, bears little relation to the situations that she will certainly confront in the community sooner or later. Our professional group as a whole has had even less specific training in understanding the intellectually inferior or superior individual than in understanding the mentally ill. The information given here does not cover, or even suggest, all that the nurse will wish to know as a basis for her work with these patients. Instead it focuses on some of the questions and situations that we frequently meet.

The extent to which we need training in psychiatric nursing per se is evidenced by statistics furnished by the American Red Cross and quoted by Dr. William C. Menninger.<sup>68</sup> Of the 75,029 nurses who served in the Army and Navy services during World War II, 16 per cent had psychiatric nursing during their basic training; only 0.7 per cent had any preparation in psychiatric nursing as graduate nurses. Clearly, research is needed to find the most effective method and to determine the period of time that will be required to supplement the experience of many graduate nurses in this respect.<sup>74</sup>

Two groups of individuals in the community differ mentally in some noticeable degree from persons considered normal. These groups are the intellectually abnormal and the mentally ill. The intellectually abnormal include those who are intellectually superior as well as those who are mentally defective; mental defect always means intellectual inadequacy. The mentally ill patient, on the other hand, may have the intellectual ability to grasp facts but may distort them because of his organic or functional mental disease. While it is possible for an intellectually abnormal individual to have a mental disease, the terms cannot be used interchangeably. The discussion of mental disease in this section will be limited to patients who are definitely ill mentally and to those with psychoses rather than psychoneuroses. Among the patients whom the nurse is trying to help are people with so-called "personality problems." They show considerable mental and emotional pathology but remain in the community because they are

not sufficiently disturbed to be hospitalized. It is difficult to build a rapport with such people, and this is the crux of the nurse's problem in working with them. Such situations have also been discussed in previous chapters.

### THE INTELLECTUALLY ABNORMAL

It is interesting that we so often forget to include the intellectually superior person among those who deviate from the average in intellectual endowment. Yet intellectually brilliant individuals often have problems that are difficult to meet. The young child whose mind has outdistanced his physical and social development needs special understanding at home and at school. He may be far beyond his parents in intellectual capacity, and in that case his school may be the only place where he can get stimulation and understanding. His capable intellect may be of more harm than help if he does not learn stability and is unable to get on with other persons. He may in reality be a less successful person in the end than the dull child who is persevering and who is capable of happy relationships with others. An often used but vivid illustration of this is the master criminal whose brilliant mind has not saved him from rebellion against society but has simply enabled him to rebel more dangerously. The fact that members of some of the families whom the nurse visits may be intellectually superior has a direct bearing on the nurse's teaching methods; furthermore, the content of her material must be enriched if such patients are to be interested in what she has to offer.<sup>27</sup>

However, the nurse is more often called upon for direct help with the intellectually inadequate person than with the intellectually superior one. She needs to know, with respect to these patients, what resources the community offers for their diagnosis and for institutional care or training, and the ways in which she can help such patients in their homes. This will include assisting parents to understand and train their mentally defective children and helping intellectually inadequate adolescents and adults, who are often carrying responsibilities which are beyond them, to find their place in the community. With these patients, as with the intellectually superior, the nurse recognizes that the degree of intellectual ability must always be considered in relation to the

degree of possible social adjustment, even when the patient has a very low-grade intelligence.

A question frequently asked of the nurse is whether or not the *innate* intellectual capacity of the individual can increase under optimum conditions. For example, we have been hearing and reading recently about the use of glutamic acid as a means for increasing the intellectual level of the individual. In an article entitled *Implications of Mental Deficiency*, Dr. Irwin Goldstein says, "As far as is ascertainable at the present time, mental deficiency is incurable and irremediable." "He reminds us that simple, primary mental deficiency implies amentia (not dementia) and constitutes arrested or incomplete development. With regard to the use of glutamic acid, the article states, "It appears that glutamic acid does not so much influence or increase the intellectual ability as such but only enables the patient to regain his intellectual function which was inhibited by other mechanisms." As we know, this medication must be given continuously if it is to exert any effect. Dr. Edgar A. Doll, known to us for his work at the Training School at Vineland, New Jersey, is quoted by Dr. Goldstein:

The most we know about medical cures as contrasted with social and educational amelioration is:

1. that some cretins respond to chemo-therapy;
2. that some infantile cerebral palsies respond to physical therapy;
3. that surgery sometimes relieves some symptoms;
4. that diet and regimen sometimes advance the expressive aptitudes of some patients within limits; but,
5. that few if any of these therapies are sufficiently potent, consistent or permanent to really alter the genuine psychosomatic constitution of the individual so as to effect a transfer from genuine feeble-mindedness to genuine normality."

Another issue that we hear debated — sometimes without adequate factual background — has to do with the advisability of sterilization for the mentally deficient adult. Some statistics appearing in the article quoted above help us to understand this problem.

The general consensus at the present time seems to be that 40 to 50% of mental deficiencies are of an hereditary nature; approximately 20% are due to some form of glandular imbalance; 23% to birth injury; and about 10% to miscellaneous causes, such as concussion, brain inflammation, syphilis, etc. Thus it is believed today that a greater number of cases of mental deficiency falls within the secondary group (acquired)."

No matter where we work, we are sometimes confronted with the need for diagnostic resources as an aid in understanding the mental status of children who may be mentally defective, and for learning something of what the future holds for them. Such resources are developing fairly rapidly, though they are not yet available, easily or perhaps at all, to all of us. Perhaps it is safe to say that there is less danger than previously that diagnosis will be established on the basis of a brief physical examination by a general practitioner, a so-called psychological examination administered by an untrained person, a single psychological test, or an inadequate or unrepeated battery of psychological tests. The best diagnostic procedures include study of the child's environment and of his adjustment to it, to his family in particular, and, if he is of school age, to his school. The information that the nurse has about the child can be invaluable here.

Actually, it is hard to define what, for purposes of everyday living, constitutes feeble-mindedness. Many states have established an intelligence quotient level at or below which an individual may be admitted to a state school for the feeble-minded. Often this I.Q. is acceptable to the state if based on the results of one type of test only — the Stanford-Binet. However, the normal variation in the results obtained by this test, the impossibility of stating results at a precise figure, and the failure to take the child's social behavior into consideration in assessing his need for institutionalization work hardship on children and often make the task of the placement agency impossibly difficult. For example, if a state institution will not accept children having an I.Q. higher than 75, a child having an I.Q. of 77 will be kept out of the institution although the 2-point difference has no real significance whatever. In other words, the accepted legal criteria for feeble-mindedness do not seem satisfying in all instances.

Similarly, the established fact that a child is "educationally" feeble-minded does not tell the whole story about him. It does show, however, that at the time he is tested he is different from, and in that respect inferior to, most children in his culture.

Whether or not an individual is "socially" feeble-minded may be a most useful criterion. In this connection Dr. A. F. Tredgold writes:

Above the stage of imbecility it is much less easy to forecast the amount of development likely to take place; indeed it is often impossible to do this without watching the child's progress for a time. Undoubtedly there is often a close relationship between response to scholastic education and general intelligence with consequent usefulness; but this is by no means invariably so, and the physician must guard against basing his forecast entirely upon the extent of the child's educational attainments. . . . Even the I.Q. is a very uncertain guide in progress as well as prognosis. The best indication is afforded by observation of the child's response to "performance" tests, of the manner in which he adapts himself to his surroundings, and of his degree of mental equilibrium. The mentally stable child who shows evidence of some practical capacity and intelligent adaptation to his surroundings, even if he has a low I.Q. and is markedly defective educationally, will usually develop to a higher standard of usefulness than will the one who is unstable and whose behavior cannot be depended upon even though he may have a far greater range of school experience. It must be remembered, however, that mental development of the defective comes to an end earlier than in the non-defective. The important years of life are the early ones, and if proper training is not given in these early years, the child's developmental potentiality may never be realized, and he will remain far more defective than he need have been.<sup>208</sup>

The closing sentences of the above quotation emphasize again how close the nurse's functions bring her to the best opportunities for preventive work in mental hygiene. In addition to having this opportunity to recognize mental deficiency in young children and to help in their training, we are called upon to make some practical evaluation of the intellectual capacity of adults, often parents in whose homes we are working, so that our methods of work can be appropriate. Neither age group is simple to observe. Again we need accurate knowledge of the way in which children usually develop, and knowledge of the different causative factors that may bring about seemingly identical responses in adults, some of which may be mistaken for feeble-mindedness.

We realize, for example, that it is unsafe to judge a patient's intellectual capacity by his appearance alone. Racial or individual facial characteristics may seem peculiar when judged by the nurse's personal standards and may lead her to a wrong estimation of the patient. If the judgment of the individual nurse were the criterion, many of the higher grades of mental deficiency, especially secondary mental deficiency, would go unrecognized, since persons thus afflicted often do not bear the stigmata of low-grade mental defectives. As a matter of fact, such patients may

be rather attractive in appearance. Nor can habitual facial expressions be relied upon as a criterion. We know, for example, that many deaf persons appear dull because they are cut off from the activities of others, not because they are mentally incapable of joining in them. A devastating experience may cause an individual to seem mentally defective to the nurse who sees him for the first time. One such patient was reported as obviously feeble-minded by a nurse who had visited her hut had been unable to interest her or even to rouse her from apparent apathy. On the nurse's next visit the patient was a noticeably different person. She explained that on the morning of the previous visit she had received bad news and had not been able to speak of it to the nurse, whom she had known only a short time.

While giving due consideration to the danger of superficial judgments, the nurse will find many points in the behavior of her patients that will guide her in estimating their intellectual capacity.<sup>56</sup> After a number of visits she will know whether parents are able to understand simple abstract material and to make such calculations as may be necessary in preparing a baby's formula or in giving medications. She will recognize that even when a mother is obviously interested, she may not be able to remember from one visit to the next the reasons the nurse has given for certain simple suggestions. She will see that certain parents cannot apply the reasoning process they have used in one health situation to another similar situation, and will be aware of a lack of judgment on their part. These observations need to be compared with the family's judgment and success in other matters, since health procedures which seem simple to the nurse may be foreign and complex to persons with a different background. Confusion, inability to remember, and apathy may also be symptoms of psychoses.

That intangible quality which may be described as zest for living is lacking among the definitely mentally deficient. A mentally deficient individual may indeed be physically active. His activity could be better described as restlessness, however, and may result from the fact that he is able to express himself best on the motor level. In the course of gathering this material, several groups of mentally deficient children were observed at work and play, and later a visit was made to a cottage belonging to an



institution in which mentally normal children suffering from birth injuries were living. As we opened the door of this cottage a small boy, beading for his playthings which were on an upper floor, ran upstairs as fast as his limp would let him. "You'd never see one of the mentally deficient children doing that," was the comment of the attending psychologist. He went on to say that even infants show that intangible something that implies adequacy. This characteristic is mentioned here not only for its value as a symptom — doubtful in the hands of anyone but an expert — but for the heartening thought that intelligence, which forces upon one the ability to recognize disaster and confusion, also imparts an indescribable vitality to the individual.

Although a number of outstanding psychologists have developed tests for measuring the mental development of infants and small children, examinations for this age group are less reliable for this age group than for older children and adults. On what criteria can the nurse rely when no such examination of an infant is within the resources of the community? For instance, she may need criteria of development when called upon for help in training a child whose parents are not ready to recognize his marked abnormality or the need for an examination. In estimating the abilities of infants and preschool children, significance can be placed to a considerable extent on certain criteria of development which, taken in conjunction, suggest the degree of intellectual adequacy. These criteria are: time of dentition; time of walking without support; time of talking in sentences. Retardation in any one of these alone is thought to have little significance, but marked retardation in all of them may represent mental inadequacy if serious illness has not been an obvious causative factor. The first two criteria are not accepted by all psychologists. It has been said in refutation of them that the teeth, already formed at birth, are merely one of our appendages and that delayed walking may have to do with inadequate motor control and nothing more. Definitely delayed talking, however, is accepted by almost everyone as an indication of intellectual retardation, with the reservation that a child who has no need to talk because others do his talking for him, who does not want to talk because he enjoys infantile dependency, or who has local organic impairment may show delayed speech without being intellectually deficient.

Since it is not the nurse's function to make the actual diagnosis, she need not be confused by the somewhat differing views on the diagnostic value of developmental criteria. These differences may even create a healthy doubt in her mind so that she will observe the infant or child more closely and over a longer period of time before reaching a decision about him. Her best plan probably will be to study those activities of the infant or child that necessitate thought and adjustment on his part and to weigh them against what she knows about his degree of independence since, as suggested, he may be showing social immaturity rather than intellectual inadequacy. Her observations will be helpful to the physician who may be called upon to make a diagnosis and who, like the nurse, may be denied the opportunity to arrange a psychological examination for the patient.

In working with mentally deficient infants and small children the nurse immediately faces the same problem she has encountered in her work with children who have a physical defect — the problem of the parents' attitude toward the child's condition. But since it seems easier for the majority of persons to admit a physical defect, the problem of the parents of a child with mental defect is intensified. The child's assets are played up by the parents and his weaknesses are glossed over. His symptoms are misinterpreted; often a physical basis is claimed for symptoms that cannot be overlooked. For example, children who obviously have been mentally defective at birth are often said by parents to have been normal previous to "a fall." The need to explain the child's condition on a physical basis is increased by the parents' feeling that something must be wrong with themselves or with their inheritance if they have produced a mentally defective child.

Perhaps the physician or psychologist has made a diagnosis of mental defect which the parents do not accept. Perhaps the physician has thought it best to dodge interpreting the child's condition to his parents. Perhaps no examination is possible. In any case, the nurse can stand by, developing and deepening her relationship with the parents, especially with the mother, until such time as they can face the situation and accept more direct help. If the nurse attempts to hurry this process, the parents may reject her help entirely, not only for the defective child, but for the entire family.

The following instance illustrates the dangers and possibilities in such a situation. At the time a new nurse entered their home, the family consisted of young parents, a preschool child, and an infant. The older child seemed to the nurse definitely mentally defective. No examination had been made. Evidently the former nurse had tried in a gingerly way to show the mother that the child was "backward." The mother had not been ready to recognize this and had become quite hostile to the nurse so that her work with the normal infant also was hampered. The new nurse bided her time with John, the older boy, and was able through the health station service to be of real assistance to the mother in the care of the baby. The mother's awareness of the older child's condition was shown by the fact that she invariably made arrangements to leave him at home when she came to the health station and by the fact that she never talked about him. After four months the mother herself brought up the subject of John's condition. She said he seemed "queer." The nurse suggested that a doctor's advice would be helpful and left the making of an appointment with the physician to the mother, after explaining how this could be done. The mother made three appointments and broke each one. The examination, when it did take place, showed the child to be definitely mentally deficient. However, for some months previous to the examination, the relationship between mother and nurse had been such that the immediate problem of training this defective child could be discussed and simple methods worked out.

The nature of the help that the nurse should give depends on the degree of the child's deficiency, and also on the parents' ability and resources. Such a problem was presented by a family consisting of a mother and nine children, the youngest of whom, four years old, was a completely helpless idiot who could not sit up and who took no food but fluids. In this instance the nurse helped the mother to care for the child's emaciated body by visiting the home every two weeks, by demonstrating, and by giving suggestions. The mother depended upon the nurse for more than this, however. The nurse appeared to her as the one person who shared her difficult burden. It was interesting that the mother could not bring herself to give up the care of the child even temporarily, when the nurse made this possible. Later, after the child had died

from pneumonia, the mother seemed lost and needed the nurse's help in adjusting to the unaccustomed ease of unbroken nights and less demanding days. This situation illustrates the type of help which a nurse may offer the family of a helplessly mentally defective child. It also shows a mother too exhausted to care for the normal members of her household because of her great need to "make up" to the defective child for his condition, a condition for which she consciously or unconsciously may feel to blame. Neither the nurse nor the worker from a family agency seemed able to help this mother overcome her need to compensate.

Awareness of the child's probable mental age gives a foundation for building habits in these children. How old is the child, not in years and months, but in social adjustment and in what he is able to do? It is not always possible to clarify this by means of a psychological examination. But the mother knows the child's achievements in simple speech, toilet training, attempts at helping himself, and similar activities. She knows in general, too, how these compare with the achievements of other children. Often she herself can be led to estimate and express the child's mental age with considerable accuracy. She may say of her four-year-old, "He acts more like a two-year-old child." Agreeing that he is indeed "young for his age," the nurse can then help the mother to plan activities suitable to his mental age. When a child with the mental age of two has the size and appearance of a four-year-old, one can see how important it is to be able to estimate his mental age so that he may be given credit for whatever achievement he is capable of and not be expected to do more.

When the child's mental age is the basis for training, an attitude of kindness and patience is more easily aroused in parents and others who work with him. On the other hand, it is more difficult for them to grasp the concept of intellectual capacity. Furthermore, so many unpleasant associations have grown up around the idea of mental defect, so many crimes have been laid, often erroneously, at the door of the mentally defective, that terror and misunderstanding rather than tolerance follow an attempt to explain the child's condition in these terms.

With the concept of mental age as a basis, methods for training mentally defective children do not differ from those used with normal children. That is, the defective child, like the normal child,

learns certain habits and ways of behaving because they give him pleasure rather than pain and because they are interesting to him. Therefore the behavior he is to learn must be made a happy experience for him and must hold immediate incentive. While the mentally defective child may not be able to grasp the reason for the behavior suggested to him, he is able to sense approval that is consistently offered in ways other than speech.

One important difference stands out, however, between the ways in which the mentally defective child and the normal child show progress in learning. This in turn affects training methods. The normal child matures through an established series of developmental phases that are being clarified by current research. However, while he is actually progressing step by step, he is apparently developing in a series of explosions. One day he is creeping; soon he walks. One day he becomes interested in buttons and button-holes; almost at once he may be able to put the button through its hole.

The mentally deficient child, on the other hand, progresses by a more minute and painful accumulation of things that he can do. The following analysis of steps in putting on underwear, part of an analysis of similar training problems of the low-grade defective made at the Training School at Vineland, New Jersey, shows this minute and painful progress — really a slow-motion picture of what the normal child can accomplish with much greater ease:

Puts legs in; puts arms in; puts whole garment on, but must be buttoned up; must have garment put on for him, but is able to button it up; in buttoning garment, does not get proper holes and buttons together; in buttoning garment usually gets proper holes and buttons together; able to get button halfway through, but unable to complete the process; able to properly put on and button his own underwear.<sup>22</sup>

The low-grade mentally defective patient may become stalled at any of these levels, having reached for the time being the limit of his ability. When he is able to go further, it is a formidable, step-by-step process.

This suggests to us that the child will be less confused in his attempts at learning if "units" of activity are worked out for him by his mother, teacher, or nurse, each activity being carried out in the same way and a new one given him only after he has mastered the step already presented.

It has been demonstrated that many useful habits of self-help can be learned by individuals of so low a grade intellectually that they are classified as idiots. Too often a family may be satisfied that a low-grade child has reached the limit of his capabilities when this is by no means the case. It is true that children of borderline mental deficiency, whether or not their condition has been recognized, may be cruelly pushed beyond the limit of what they can accomplish. But there is another side of the picture: the nurse going into a home often sees parents who, pitying the comparatively helpless, low-grade feebleminded child, fail to give him as much training as he can take. They adhere unnecessarily to infantile methods in the care of bodily functions. For example, many boys coming for the first time to an institution for the mentally deficient have never been taught to stand before the toilet for urinating, although their general physical condition would easily permit it. This obvious step in self-help could be taken at home. An institution for these children starts to teach it at once.

Although we approach our work as public health nurses from the positive aspect, we still can learn much from the pathological. *Lessons in Child Training Gleaned From Idiots* is the title of one such study. The points brought out by the author as the results of her experimentation are quoted below to emphasize the value of routine for the mentally deficient individual and to summarize much of the preceding material. The order of the statements has been changed to correspond with the development of material in this section:

It is wrong to assume that a child's failure to learn is due to sheer stupidity until every possibility of increasing the incentive has been exhausted.

It is just as simple to build up pleasant associations around obedience as it is to build up unpleasant ones around disobedience, and after such conditioning the child should continue obedient as a matter of course.

The slow or retarded child . . . must have his world organized more systematically by his teachers if he is to approach the standard of training of his more precocious playmates.

Training should be so systematized as to allow only one solution to each problem until it is too thoroughly learned to be confused with alternatives.

The final achievement desired must be kept in the mind of the child of this level, and must receive his constant attention. . . .

For those children who learn most readily, it is of even more importance to see that the correct habits are established first, since the ability to retain is apt to be as strong as the ability to learn.<sup>1</sup>

Turning to the older group of mentally inadequate children whom the nurse sees in the community, one finds additional problems. The experience of nurses suggests that the children in this age group who are above the threshold of feeble-mindedness can be greatly helped by care and training. The intellectual inadequacy of many of these youngsters is often not sufficiently marked to be noticed during infancy and preschool days while they are protected by the home environment. If the child must bear comparison with considerably more brilliant brothers and sisters, it will be obvious that he is less intelligent. But even then, the real reason for his difficulties may not be understood until he is of school age. When he gets older, he must go to school, attempt to meet other children as an equal, assume increasing responsibilities. At the same time, he may be approaching, or may have reached, the limit of his intellectual development. At any rate, his mental age will not equal his chronological age. He is beginning to show maladjustment by all sorts of symptoms which originate, at least partially, in inability to meet demands at school, in the home, and in the neighborhood. Troublemaking at school to cover the fact that he cannot learn as fast as others, truancy, rebellion at home against demands that are overwhelming to him, association with younger children or blind following of poorly chosen neighborhood leaders, and many other forms of behavior may all be indirect symptoms of intellectual inadequacy, when it is unrecognized and the child is unaided. The child himself does not understand his own difficulty, though by this time he may have been told so frequently that he is "dumb" that he feels inferior. Three qualities are especially characteristic of boys and girls who are not of average intellectual endowment but are by no means feeble-minded. They lack judgment, they are easily influenced, and they want to be like others.

The nurse's responsibility in helping to meet the needs of these children will depend upon the resources of the community in which she works. In many communities, other agencies such as the school will take the leadership by establishing guidance facilities, which may include the services of psychiatrist, psychologist, and psychiatric social worker, the latter confusingly known in the school setup as a visiting teacher. Under such circumstances the public health nurse's function will usually be to make sure she is

working in cooperation with the guidance service. In large communities where no such service is available, the situation is immeasurably discouraging. School classes are large, children are pushed along through the grades, individual problems cannot be given enough attention. In smaller communities nurse and teacher can at least know the individual child well and can make an attempt to fit his program to his needs, bearing in mind that their purpose is to equip him to make his own way as far as possible instead of doggedly trying to force him to meet certain academic standards.

Institutionalization is possible for the age group of which we are now speaking. Until a child reaches a chronological age of about seven, state residential schools for the most part cannot accept him, and the expense of private institutions or foster home care is often prohibitive, when they are available. Then the question arises, which of the mentally retarded or deficient children shall be sent to such a school? Many of the low-grade feeble-minded are sent to institutions as soon as they reach the age of admission. Unmanageable children of higher grades of mentality will also usually be shifted to the more expert care of training schools. But it is not easy to decide about the borderline child.

Miss Elise Martens, in an especially helpful handbook, *Parents' Problems with Exceptional Children*, discusses exceptional children under four groupings: the physically different child; the exceptionally bright child; the mentally retarded child; the socially different child. She quotes the following passage from an annual report of the Wrentham State School which describes in general the children who can profit from training at a school for the mentally retarded or defective:

The work thus indicated for the institutional school is education and training of the children on low mental levels; training and education of mentally retarded children on the higher levels who are deficient in social adjustment and who are likely to acquire habits which will prevent them from becoming socially adjusted in the community; the training and education of mentally retarded children on the higher levels whose homes cannot provide them with the proper care and supervision or whose homes are so situated that these children cannot avail themselves of the advantage of a special class.<sup>4</sup>

Again the attitudes of parents form a very real part of the picture. It is no wonder that many parents hesitate to send their child away from home to an institution. Many institutions are so



crowded that it is impossible for them to carry out their educational purposes in full. Many parents are afraid of hospitals and institutions in general. They feel, too, that a certain stigma is attached to the child if he is sent to a "home for the feeble-minded," since the emphasis these schools are now putting on education and training is so recent that many people in the community still think of them as giving only custodial care. Institutionalization is to many parents a final admission of the child's inadequacy. Added to these general attitudes are more personal emotional reactions. For these reasons, considerable resistance may be raised to "sending the child away" even though home care is obviously inadequate.

Under such circumstances, the nurse may have the task of interpreting just what institutionalization can do for the child—its advantages in terms of benefit to the child himself. Probably she will find that she must repeat her explanation again and again after the child has been placed in the institution. The difficulty or the impossibility of managing him at home, the misery he has helplessly created, the fact that the community school has no adequate place for him, all this has faded from the parents' minds, leaving only the feeling that they are not themselves caring for this unfortunate child, who is inadequate through no fault of his own. This is understandable. If the nurse realizes what lies behind the family's demand for the return of the child, she can quietly reinterpret the help the child is receiving as many times as may be necessary to reassure the parents. Eventually, perhaps, he will be able to return home.

Occasionally the nurse must meet the problems of adult defectives, as when a hopelessly low-grade adult is being cared for in his home, or when the hospitalization of such a person is requested by his family, or when intellectually inadequate adults are attempting to maintain homes of their own. It is the last situation that presents the greatest problem in work with adult defectives.

Often she is called upon to play an important part in deciding whether it is safe to keep the family together. Usually the welfare of the children is the determining factor in such a decision. One can hardly imagine circumstances that would demand clearer thinking on the part of the nurse or more careful separation of her own personal ideal of family life from conditions in a partic-

ular home. How important in a given instance, for example, are dirt, confusion, and a day-by-day, or perhaps even a meal-by-meal, plan for family living? The objective findings which the nurse can offer to a case conference or can use in making her own estimate in such instances relate primarily to the physical condition of members of the family, especially the children. Here she either has medical examinations to back up her own inspection, or she can demonstrate the crying need for medical examination, refused by the parents. This information, as complete, as specific, and as accurate as possible, is invaluable in estimating the family's condition. Next, she can contribute facts as to the choice and preparation of the food provided by the parents. Her estimate of the way in which the household is managed will depend not on whether this home is one in which she could imagine existing herself, but on whether there is sufficient use of the warmth, food, shelter, and safety measures available to make health and growth possible. She will also consider, on the basis of her experience, how far it is possible to teach members of the family the simplest measures for safe and healthful living. Nursing records show instances of babies who have died from pneumonia or from injuries caused directly or indirectly by the mother's mental deficiency. Responsible agencies bear in mind the importance which life in a family — even a regrettable kind of family — has for the individual and may, after considering all the adverse factors, suggest a plan that will not rend the family asunder but will strengthen their resources on all fronts, in some cases even providing the children with recreation outside the home. The plight of mentally inadequate parents when some or all of their children have been taken from them is pitiable. They are bewildered and at a loss. Rarely are they appropriate patients for already crowded institutions. Often they merely proceed to have more children. Situations of this kind appear again and again in the work of the public health nurse, and indicate the need to help such people make their homes fit places for their children if it is at all possible to do so. On the other hand, many of us have known people who should not have been allowed to stay together as families; who, in spite of help from the community, could not make safe homes for their children; whose children, likewise, would have benefited from early placement in foster homes where they could form strong family

crowded that it is impossible for them to carry out their educational purposes in full. Many parents are afraid of hospitals and institutions in general. They feel, too, that a certain stigma is attached to the child if he is sent to a "home for the feeble minded," since the emphasis these schools are now putting on education and training is so recent that many people in the community still think of them as giving only custodial care. Institutionalization is to many parents a final admission of the child's inadequacy. Added to these general attitudes are more personal emotional reactions. For these reasons, considerable resistance may be raised to "sending the child away" even though home care is obviously inadequate.

Under such circumstances, the nurse may have the task of interpreting just what institutionalization can do for the child — its advantages in terms of benefit to the child himself. Probably she will find that she must repeat her explanation again and again after the child has been placed in the institution. The difficulty or the impossibility of managing him at home, the misery he has helplessly created, the fact that the community school has no adequate place for him, all this has faded from the parents' minds, leaving only the feeling that they are not themselves caring for this unfortunate child, who is inadequate through no fault of his own. This is understandable. If the nurse realizes what lies behind the family's demand for the return of the child, she can quietly reinterpret the help the child is receiving as many times as may be necessary to reassure the parents. Eventually, perhaps, he will be able to return home.

Occasionally the nurse must meet the problems of adult defectives, as when a hopelessly low-grade adult is being cared for in his home, or when the hospitalization of such a person is requested by his family, or when intellectually inadequate adults are attempting to maintain homes of their own. It is the last situation that presents the greatest problem in work with adult defectives.

Often she is called upon to play an important part in deciding whether it is safe to keep the family together. Usually the welfare of the children is the determining factor in such a decision. One can hardly imagine circumstances that would demand clearer thinking on the part of the nurse or more careful separation of her own personal ideal of family life from conditions in a partic-

ular home. How important in a given instance, for example, are dirt, confusion, and a day-by-day, or perhaps even a meal-by-meal, plan for family living? The objective findings which the nurse can offer to a case conference or can use in making her own estimate in such instances relate primarily to the physical condition of members of the family, especially the children. Here she either has medical examinations to back up her own inspection, or she can demonstrate the crying need for medical examination, refused by the parents. This information, as complete, as specific, and as accurate as possible, is invaluable in estimating the family's condition. Next, she can contribute facts as to the choice and preparation of the food provided by the parents. Her estimate of the way in which the household is managed will depend not on whether this home is one in which she could imagine existing herself, but on whether there is sufficient use of the warmth, food, shelter, and safety measures available to make health and growth possible. She will also consider, on the basis of her experience, how far it is possible to teach members of the family the simplest measures for safe and healthful living. Nursing records show instances of babies who have died from pneumonia or from injuries caused directly or indirectly by the mother's mental deficiency. Responsible agencies bear in mind the importance which life in a family — even a regrettable kind of family — has for the individual and may, after considering all the adverse factors, suggest a plan that will not rend the family asunder but will strengthen their resources on all fronts, in some cases even providing the children with recreation outside the home. The plight of mentally inadequate parents when some or all of their children have been taken from them is pitiable. They are bewildered and at a loss. Rarely are they appropriate patients for already crowded institutions. Often they merely proceed to have more children. Situations of this kind appear again and again in the work of the public health nurse, and indicate the need to help such people make their homes fit places for their children if it is at all possible to do so. On the other hand, many of us have known people who should not have been allowed to stay together as families; who, in spite of help from the community, could not make safe homes for their children; whose children, likewise, would have benefited from early placement in foster homes where they could form strong family

ties with reliable foster parents. The authority to "break up a home" is given to certain community agencies by the community. This authority is a painful responsibility. When the nurse contributes to the decisions of these agencies she tries to do so by using the most thoughtful professional judgment she possesses, based on careful observation of the family.

Other parents who are somewhat below average mentally are often "good" parents, respected in the community. While the intellectual stimulation they can give their children is limited, they offer them a home life of considerable security. Teaching adapted to the individual needs, capacities, and interests of such parents is the most important part of the nurse's function under these far more hopeful conditions.

### THE MENTALLY ILL

The public health nurse also meets in the community psychotic and prepsychotic persons and those recovering from mental illness, for not all people with a psychosis or psychotic tendencies are within the walls of hospitals. She has a grave responsibility for helping such patients. Frequently she has an opportunity to recognize symptoms of mental disease early enough to obtain prompt medical treatment for the patient. At other times she comes upon a patient in the grip of an actual psychosis and is able to secure help for him and his bewildered family. Hospitals for mental disease attempt to maintain contact with patients who are returned to the community "on parole"; some that are able to place certain patients in private homes for "family care" carry the responsibility for their supervision also. It is not yet possible, however, for hospitals to employ the large staff of social workers required for follow-up of patients returned to the community, and hence the nurse may have to take this responsibility if the patient is a member of a family she visits, whether or not any definite cooperative arrangement has been planned by hospital and nursing organizations. The crowded condition of many large hospitals or pressure from relatives may necessitate the return of patients to the community before they are ready to be plunged back into the responsibilities and activities of life outside the institution. It seems obvious that the pub-

lic health nurse must at least be familiar with symptoms of mental disease and must know community resources for the help of such patients. Furthermore, her understanding of human behavior is limited unless she is aware of the whole range of it, including the frank psychoses. There is so much that is "normal" in the behavior of the psychotic patient, and so much that is "abnormal" in the comparatively well person.

The following brief excerpt from a nursing record illustrates the kind of help the nurse is sometimes called upon to give the family of a mentally disturbed adult. The family was known to the nurse because one of the children was tuberculous:

4/19/—. John is home again from ——— State Hospital. Correspondence with hospital shows diagnosis of dementia praecox. He walks up and down the room restlessly and at times does not seem to understand and does not respond to questions. Telephoned description of patient's condition to ——— agency which arranged former hospitalization.

4/25/—. John has been returned to the State Hospital. His mother wants him home again. She is upset because patient was taken suddenly after re-examination at city clinic. Expressed understanding of her disappointment but explained that John is still too sick to stay at home. Letter written to the hospital asking report of patient's condition and guidance in explaining this to family.

Another record shows that a discharged patient diagnosed as schizophrenic went to bed on her return home and refused to dress or take nourishment. The family thought the patient needed rest. Fortunately the nurse realized that the patient's recovery was dangerously incomplete.

Changing concepts in present-day psychiatry help to clarify the function of the public health nurse in relation to the mentally ill who are living in the community. Institutions for custodial care are gradually changing into hospitals where mental illness is diagnosed and treated. To a certain extent we have accepted the fact that a psychosis is an illness, just as tuberculosis is an illness, and that no more tragedy is attached to the one than to the other if the prognosis is equally favorable.

While, on the one hand, psychiatry is making use of special and, occasionally, of specific forms of treatment, on the other hand it is demonstrating that psychoses once thought capable of clear-cut classification have perhaps no such clearly defined diagnostic groupings. Malarial fever is used successfully in the treatment of

tertiary syphilis. Shock treatment may be beneficial to many patients who are pathologically depressed although the exact way in which this treatment acts is not clear. In contrast to the use of these special treatments, one finds old diagnostic lines increasingly broken down where the functional psychoses are concerned. The "puerperal psychosis," for example, is no longer accepted as a separate form of mental disease, and it is now thought that the strain of maternity is merely a precipitating factor in a patient already unstable. Schizophrenia<sup>18</sup> and manic depressive psychoses often do not present classic pictures. This would be confusing if one felt the study of a particular disease rather than the study of the patient to be the important activity. However, it is the patient, not a medical formulation, that is at stake, and research and nosology are changing in accordance with this concept. In *Destiny and Disease in Mental Disorders* Dr. C. Macfie Campbell expresses this idea as follows:

The dominating trend in psychiatry . . . became the emphasis on the personality and on the conception of the psychosis as the revelation of the personality grappling with its special tasks. The problem of the psychiatrist was no longer to identify a clinical picture but to get to grips with the actual dynamic situation, to reconstruct in detail the life history, with attention to the sensitizing or conditioning influence of environmental factors, and with due appreciation of the nature of emotional disturbances, of substitutive and evasive reactions, of symbolic expression, of the various modes of getting satisfaction for the complicated needs of the individual.<sup>19</sup>

World War II brought psychiatrists face to face with the problem of diagnostic labels and classifications in a compelling way.<sup>20</sup> The difficulty is seen by some psychiatrists to be that previous classifications of mental illness were based primarily on the complex of symptoms that the patient showed rather than on the dynamics of conflict and the individual reaction to conflict or impairment underlying the symptoms.

At present there is no definite assurance that work with children will contribute directly to the prevention of functional psychoses, although it might to the prevention of neuroses. This is not to say, however, that the small child diagnosed as schizophrenic cannot be helped by skilled psychiatric treatment.

It seems possible that as general hospitals provide units for mentally ill patients,<sup>21</sup> as psychiatric consultation becomes more

Other patients, however, appear depressed without discoverable cause, or react in an extreme way to pain and difficulty. The patient whose depression has not reached the stage of demanding hospital care may be helped toward recovery in his own home.

A mother and two small children contracted typhoid fever and were hospitalized at the same time. The younger of the children, a little girl, died. When the mother returned to her home as a convalescent, she was still a carrier and was confined to her bedroom by physician's orders. She had nothing with which to occupy herself except constant thoughts of the child who had died. By the time bacterial examinations were negative, the mother was too depressed to want to leave her room or to take up her household tasks. The husband secured a housekeeper and the mother's uninterrupted concentration on her grief continued. By then aware and alarmed, the nurse consulted the physician. They planned that the housekeeper should come for shorter periods, that the remaining child should be allowed to make demands on his mother's time, and that the patient's condition should be made clear to her husband, who was becoming impatient with her. Neighbors were encouraged to visit and to entice the mother out of the house as much as her formal mourning would permit. Finally the family moved to another apartment near intimate friends. The mother improved after this change though she still complained of an occasional dizzy spell — "like drunk" — and said she saw her little girl occasionally, out of the corner of her eye. She expressed a desire to do her own housework and became interested in making the new home attractive.

When the normal person is temporarily depressed because of difficult conditions, he may weep, complain of feeling unhappy, and for the time being feel that he is a victim of circumstances. A serious degree of depression is not necessarily manifested by tears and by inability to see anything but the unhappy side of life. It may also be shown by a slowing down of the whole individual in motor as well as in mental activities. He cannot think clearly and he is unable to put his thoughts into ready action. This is a depression symptom that may be overlooked by a nurse who has not had direct experience with acutely depressed persons. The following summary from a nursing record shows a patient in this condition.



A mother was deserted by her husband, to her intense grief, shortly before the termination of her third pregnancy. On her return from the hospital following delivery, she went to a new home and so was visited by a different nurse. The mother appeared uninterested in nursing service for herself or any of the children. It was found necessary to repeat again and again the simplest instructions regarding the baby's formula. She was equally inadequate in her care of the older children. The contrast between her blank incompetence and lack of interest and her former capability as shown by the previous record indicated to the nurse that the situation needed immediate and intensive medical supervision.

The old saying that persons who threaten suicide never carry out their threat is contrary to fact. Nursing and other records are grim proof of this. Every pathologically depressed patient is a potential suicide and must be protected. Psychiatrists suggest that this protection may be more important than actual treatment since many depressions tend to clear up of themselves. Threats of suicide may not be made in so many words, but behavior and conversation indicate the direction in which the patient's thoughts are turning, often before the patient himself is entirely aware of the end he may be seeking. The agitated patient who, for reasons no one else sees, says that "life is not worth while"; the patient who discusses the fact that his work is all in order and his insurance policies are available; the depressed patient who states at length that he feels very well and ought to be allowed to go downtown by himself; and the patient who leaves despondent notes about the house, is interested in discussing the possible effect of large doses of sleeping powders, and retreats to his room, perhaps locking himself in — all are showing a need for constant supervision and protection. As suggested in the previous section, unconsciously planned "accidents" may have the effect of suicide. Helping to arrange for the protection of such a patient may fall within the province of the nurse. She will never regret the time and effort that may be necessary to save his life.

Oddly enough, one sometimes feels deflated when the patient makes no attempt to carry out his suicidal threat or when he attempts suicide by an inadequate method or under circumstances that make rescue certain. We may feel that we have been duped by an attention-getting patient. It may be true that under such

circumstances the patient was not suffering from a dangerous depression. Nevertheless, he evidently had a problem sufficiently acute to drive him to extreme methods of gaining satisfaction. Such a situation indicates that methods of treatment should be appropriate, not that no treatment is necessary. The following bizarre variation of the faked suicide indicates a need for help just as truly as though the patient had actually sought his own destruction. A husband placed a dummy of himself in bed, elaborately conveying an appearance of violent death by his own hand, wrote his wife a farewell note, then placed himself in the clothes closet to witness her reaction to his tableau. Behavior of this kind arouses disgust, even a reluctant laughter, in the layman. To the professional worker it suggests, in addition, a patient who is deeply in need of help.

It may be difficult to recognize the early stages of overactivity and to differentiate early symptoms from "learned" behavior or from personality characteristics. The patient who is on the verge of becoming dangerously overactive has, for example, a "push" of talk. But this symptom demands further differentiation in that many healthy persons verbalize easily; they may talk as a defensive measure to keep the nurse away from subjects that it would be painful to discuss; or they may have been taught to be circumstantial in speech, relating every incident in minute detail. "Flight of ideas" is often a characteristic of the excessive talking of the pathologically excited patient. His remarks rarely lead to a logical goal and progress by association of words that merely sound alike or of ideas that may be very superficially related. While he talks, such a patient walks about. He is "jumpy" as well as talkative. In other words, he is showing signs of psychomotor overactivity. Here, then, we have a means of differentiating the patient on the verge of possible mental disease from the one who will reach a goal in his conversation, given time, and from the one who finds that he can protect himself through defensive talking. A rapid mood swing may also indicate that a patient is on the verge of dangerous overactivity. It is a misleading pleasant experience to enter the home of a previously depressed patient and find him happy, elated, as sure that life means well by him as he was previously convinced that he was marked for trouble. When one stops to think, however, the realization comes that safe recovery

from depression does not arrive through sudden reversal of mood and that the present attitude is another phase of the patient's illness — an excitement and elation as exaggerated and unfounded as his former depression. It is one thing to learn about cyclical swings in textbook language; it seems to be quite another thing to recognize them in a patient in his own home setting, especially when the issue is confused by one's own relief at finding the patient "better."

Perhaps at no time are we more conscious of the differences in people — their individual ideas, their backgrounds and cultural patterns — than when it is necessary to make some estimate of the rationality of their behavior. It is so easy to veer dangerously toward diagnosis, and to state that a patient is having hallucinations or delusions or that his feelings of persecution seem to be sufficiently deep-seated and well organized to be described as paranoid. Occasionally, in such instances, a nursing record takes refuge in describing a patient's ideas as "queer." One immediately feels the need to ask, "Queer — by whose standards?" The nurse herself does a hundred things a day which seem extremely odd to those uninitiated into the thinking and techniques of her work. In addition, as an individual — the product of her own particular family life with its racial, religious, and even community patterns — she habitually behaves in a way which would seem delusional to a person from a distant land or another age. Our comics, our theaters, and our humorous magazines thrive because many of our most familiar acts become funny or farcical the moment we stop to think about them or take them out of their setting.

A partial criterion the nurse may use to differentiate behavior that seems hallucinated or delusioned from "normal" behavior is this: In what way is the behavior of an individual out of keeping with his background? If he is reacting to factors in the environment that do not exist, his behavior may be the result of hallucination; if he is misinterpreting existing factors, he may be responding to a delusion.

The psychiatrist who suggested this clarifying criterion described a small boy who had been referred to a child guidance clinic because he appeared to have active hallucinations. The child had stated several times that a devil whispered into his left ear while an angel spoke into his right ear. Study showed, however,

that the child's mother had given him this mystical interpretation of conflict in so many words, and that he was merely quoting the best source of information known to him. A very old, foreign-born woman told the nurse that she had been possessed of a devil for four years, but that she had helped the condition somewhat by massaging him from one part of her body to another. This elderly patient in a new land was undoubtedly somewhat bewildered. A diagnosis of chronic arthritis gave reality, however, to the idea that a malevolent spirit had taken up his abode within her. One would not wish to minimize the need for awareness on the part of the nurse of behavior in patients suggesting the presence of hallucinations or delusions. Her recognition of these symptoms will be of greater value, however, if behavior which seems pathological is studied in conjunction with the patient's background and environment.

Similarly, the patient who seems on superficial observation to be showing "paranoid trends" because of his complaints against society and his insistence that life has treated him unfairly may seem an ordinary enough person when studied as one of the group he represents. Perhaps his sense of injustice is representative of the minority group to which he belongs. Perhaps, as a matter of fact, he did not get a square deal in business, in education, in family life. If, however, his ideas of injustice and his bitterness against the supposed sources of his difficulties exceed those of his social group or are different from them, he may be showing symptoms of mental disease. As this individual's sense of injustice grows, he develops a logical defense so highly organized that he becomes unreachable through the ordinary means of human intercourse, and should have treatment.

How insidious, how slow in evolution such mental states may be is shown by the puzzled bewilderment of the patient's family, who often fail to understand the true significance of his increasingly difficult behavior. At first, possible reasonableness cloaks the symptomatic importance of what he says and does. Gradually, however, an individual may be recognized in his neighborhood as a chronic troublemaker, one who spreads false and scandalous reports about other persons or who accuses neighbors of maligning him. Occasionally such patients spread troublesome rumors about the public health nurse or a worker from another agency

that she may be tempted to refute hotly instead of recognizing as possible symptoms of mental disease.

One more picture of behavior closes this description of symptoms which the nurse may recognize among her patients. We are not all cut from the same piece of cloth. Some individuals enjoy being with others; they are happiest when they are in the midst of activity and have an opportunity to tell friends about their experiences and feelings. Others enjoy a more solitary existence and are reticent about their activities and emotions. The extreme of uncontrolled activity bespeaks mental illness. So, too, does the extreme of withdrawal. It is possible to withdraw so completely from reality that the individual does indeed inhabit a world all his own. However, to thrust a person who does not enjoy group activity into distasteful social life is unsound treatment. Not all children enjoy camp life or profit from it and not every boy is happy as a boy scout. Not all adults enjoy parties or clubs. But such individuals may, perhaps, be weaned to some extent from what might be called unsuccessful aloneness.

In addition to an understanding of symptoms that may indicate functional psychosis, the public health nurse needs to be familiar with syndromes that have or may have a definite organic origin. Among these are tertiary syphilis, epilepsy, chronic postencephalitis, brain tumors, senile psychosis, and, in some parts of the country, pellagra. These conditions give rise to mental abnormalities about which the nurse needs to keep informed through medical leadership and medical literature, and are mentioned here only to round out the picture.

Apparently the public health nurse finds that more senile patients are cared for in their homes than younger psychotic patients or elderly patients showing psychotic symptoms which began previous to old age. For this reason, organic psychosis will be discussed here only as it appears in old people.

The elderly arteriosclerotic patient whose illness is diffused among the small blood vessels shows some loss of memory, inability to concentrate, and a general lowering of intellectual level. His moods change easily and he responds to cheerfulness or gloom in those about him. When the large blood vessels are seriously affected, the familiar picture of cerebral hemorrhage follows. The

actual senile psychoses, however — the real mental disorder of old age — result from a progressive degeneration of the brain cells, the arteries remaining soft. Dr. Karl M. Bowman, in an article on mental illness in old age, describes the symptoms of the senile psychoses as follows:

The simple type is an exaggeration of the normal changes of old age. Loss of memory is very characteristic. The individual loses his memory for recent events but retains his memory for old events; . . . he shows little power to retain new impressions. The senile individual lives in the past. . . . Senile persons are easily upset emotionally — they have sudden outbreaks of temper. Their intellectual functions generally are impaired — they have spells of confusion. Their condition is usually worse at night and they often do not sleep well. Sometimes they become depressed; they often have delusions of having lost their property and having everything taken from them. Certain types show a special memory loss replaced by fabrication.<sup>18</sup>

Dr. Bowman suggests that older persons, whether they are cared for in their own homes or in institutions, must live simply, with little strain and excitement, and among persons who will be kindly and sympathetic. But it is not always easy for grown children to care for their parents with patience and understanding or for hospital attendants to be kind to the elderly. Perhaps the children are still emotionally immature and feel unconsciously that their parents should continue to protect them. Perhaps the unkind treatment given the old is due to a long-standing rebellion against the parents created by the parents' methods of child training. The problem of caring for the elderly is complex, based as it is on a variety of individual and social issues. The following statement may add to our understanding of the mental attitudes of elderly patients and of their special needs:

In trying to understand the mental attitudes of old people, we must remember that *all* of them are suffering from physical maladies. . . . Many old persons suffer from two or more diseases simultaneously. The diagnosis of functional disease in the aged is very hazardous. In the vast majority of cases, symptoms both physical and mental are based on definite anatomical changes in the body. Where the line can be drawn to divide the normal from the pathological changes in old age cannot be determined at the present time with any accuracy.<sup>19</sup>

Experience suggests that the actual bedside nursing or continuous supervision of a psychotic patient seldom becomes one of the

activities of the public health nurse except in the case of elderly patients. Occasionally she is called upon for emergency treatment in the preparation of a patient for hospitalization. One could sum up the activities of the public health nurse in relation to the mentally ill patient by suggesting that, in addition to understanding the symptoms of mental illness, she carries the responsibility for bringing these symptoms to the attention of a physician and of the social agency which may be involved. She may have the further responsibility of helping to interpret the patient's illness, and later the form of treatment, to his family, especially when the patient must be hospitalized. Her nearest approach to actual "mental nursing" may be an attempt to help the mentally ill patient who is convalescing to pick up the reins of his old life. Here her observation of the patient will be invaluable and her help in his adjustment may be badly needed.

In the role of interpreter to the patient's family the nurse meets the same emotional difficulties that she discovers in parents when an intellectually low-grade child is institutionalized. There is unhappiness and self-accusation at having "put the patient away." There is also a dread of the hospital itself, founded on a lack of understanding of mental disease and of the hospital's methods of treatment, and fostered by horror stories from fiction and such moving pictures as are not well directed.

Crowded conditions in hospitals contribute to the family's fear that the patient is not receiving kindly, individualized treatment, and their unhappiness is often heightened on visiting the hospital if the patient appears comparatively well and begs pitifully to be taken home or accuses the hospital personnel of abusing him. This situation, like that caused by the pathetic and almost rational letters which the patient may send his family, charging that they no longer love or want him, can be somewhat relieved by repeated explanations from the nurse, who understands that the patient's behavior is part of his illness and who also understands the reactions of the family. Her attitude can help to ensure that the patient remains in the hospital until his condition warrants discharge. It may be, on the other hand, that the family will continue to desire help from the nurse on health problems in the home while excluding her from their feelings about the patient who has

been hospitalized. They may, for example, tell the nurse that the mother is "away" — another instance of the fact that the nurse can carry out her function only in so far as the family will accept her help.



sary agency regulations. While the nurse, like any other worker, has her ups and downs, her moments of discouragement and satisfaction, on the whole she must be able to maintain a certain consistent level of work and of interest in what she is doing.

Like other workers, nurses work best under favorable external conditions. The resulting higher level of achievement is accompanied by a sense of well-being in the job that makes it easier to put one's best foot forward in relationships with other workers, both those who direct and those whom one may direct.

Adequate space, a desk or table that is recognized as belonging to the individual nurse, adequate office supplies and telephone service, and sufficient light and air affect the level of work that the nurse is able to maintain. Arrangements that will ensure privacy of interviews have become essential. The possibility of improving methods of recording the work of the nurse has been discussed previously. Because nursing agencies must lower overhead expenses in favor of service to the community, luxurious quarters are inappropriate. However, nurses' reactions to any discussion of the subject of working conditions indicate that needless discomfort and inconvenience cause them more than momentary difficulties. Favorable external conditions imply that the organization believes the services of the employee to be worth support. This in turn gives the worker a sense of belonging to the organization, a feeling of security without which she may not be able to do her best work. This is not to lose sight of the fact that public health nursing in some areas is still pioneer work under primitive and sometimes dangerous conditions, accepted by the adventurous nurse as inevitable aspects of her job.

The daily work of the nurse also reflects personnel policies concerning vacation, sick leave, salary commensurate with professional responsibilities, advancement, and annuity or pension. At the present time it is still not always possible for the nurse to know how she will support herself when she has passed the age of employability.

Nurses have certain problems in relationships that are common to all professional workers. All workers show individual differences in skill, in ability to learn, in agreeableness of personality,

and in stability, and those who belong to a professional group have a particular opportunity to develop these differences. There is more room for individual growth — an advantage even though it may add an element of unpredictability to daily work together. The professional future of the worker is also more indefinite, since the more complex our training and our personalities, the more we demand in the way of satisfactions from the job — and the more our relationships with co-workers are seen in their true complexity.

At the present time the outstanding problem that is special to public health nurses is disparity in background and formal education. Whether or not such a difference is important in all cases, it is much discussed currently and influences the relationship between staff nurses and between supervisor and nurse.

A considerable number of private and official public health nursing organizations now accept as new nurses on their staffs only those who have had a recognized course in public health nursing in addition to their basic nursing education, or whose schools of nursing have been accredited as offering enough public health nursing experience to qualify the graduate for staff nurse work in such agencies. This still leaves room for differences in background. A nurse may possess the degree of bachelor of arts or of science; she may have acquired a master's degree in addition; or she may have turned to nursing immediately after her graduation from high school. If she has been in the field long enough, a nurse may be relying on years of experience and on continuing staff programs of education to ensure her value as a nurse.

It would be a sad commentary on nursing education in general if recent graduates were not better prepared in many ways than nurses who graduated a number of years ago. If improvement does not take place as the result of increased opportunities for fuller formal education, of what use are surveys of professional needs and reformulated curricula? Perhaps many a nurse who feels that old ways are always best has not recognized the personal fear and insecurity that underlie her feeling, since there are few nurses who would not admit that nursing education in general has shown progress. This is not to say that the "older" nurse does not have her own unique contribution to make, the value of which,

especially when combined with the flexibility sometimes called a "learning attitude," she herself may not wholly appreciate.

When the newness of the young nurse has rubbed off, when she no longer sees the situations that she meets in the field in the light of her fairly recent childhood experience, when she has learned to withstand the shock of community conditions that may be new to her, considerable agreement seems to exist that her wider educational opportunities improve the service of the nursing organization. However, this is not invariably true when one considers the performance of individual nurses. At most, it is true of all nurses only to a certain extent. Therefore we can put it this way: What the nurse does with her equipment of theories, facts, and skills is more important than her mere possession of them.

Since these differences in background and education exist among both field nurses and supervisors, even though minimum requirements for appointment to staff are gradually being met by all nursing organizations, working relations between the members of the staff are not always easy to achieve in more than a superficial way. While it is understandable that this should be so, it still seems unnecessary that so much unhappiness, whether on or beneath the surface, should occasionally exist. Two symptoms of this unhappiness are disparagement of the comparatively thorough preparation of the new nurse by the nurse who has more experience than formal education; and a more or less open division in the ranks, with "older" nurses aligned on one side by their common problem and standing pat on certain methods and procedures, and the "young" nurses, eager for innovation, aligned on the other. The desire to prove themselves in a situation in which they may have been put on the defensive may, it is true, explain the zeal of the younger nurses, but they, on the other hand, might find a helpful balance wheel in the experience of the older group. Sometimes the older nurse feels almost that she has her back to the wall, while the young nurse feels like an outsider. Possessiveness flourishes in such an atmosphere. One nurse is unwilling to entrust her district, or part of it, to a youngster, no matter how well prepared she may be. The young nurse holds her cases closely as proof of her developing ability. Similar difficulties in relationships arise between the supervisor whose experience outweighs her formal preparation and the field nurse of whom the reverse

is true. Each clutches her own achievement to her, too much on the defensive to supplement what she lacks by seeking help from the other or to develop readily a respect for the other's equipment.

This particular problem in relationships is sometimes intensified by the fact that a young, well-prepared nurse may start work in an organization at a higher salary than that received by a co-worker who has been with the organization for some years. Information regarding salaries somehow becomes common knowledge. The older nurse — at least older in employment — may feel the difference in salaries to be unfair. But the nurse who has paid for an expensive professional education, or is still in the process of paying for it, feels that she is worth the additional sum, as may the director who employs her. An ability on the part of the organization and of individual nurses to face difficult issues such as these might lead to clarification, to better use of individual assets, perhaps to new policies, and ultimately to better relationships.

### RELATIONSHIP BETWEEN SUPERVISOR AND NURSE

The remainder of this section focuses on the relationship between supervisor and staff nurse. First the role of the generalized supervisor is described, and then her work with the new staff nurse and the more experienced staff nurse. Finally, some of the supervisor's own problems and the attitudes attendant on her supervisory function are grouped for discussion.

Throughout this discussion, supervision is considered to be a process, a continuous, purposeful development of the professional relationship between the supervisor and those for whom she has supervisory responsibility.

When the first edition of this book was in preparation, a number of nurses advised that no material regarding supervision be included for fear of alienating a large group of readers! This advice was not followed in the belief that our goal for the nurse-supervisor relationship was increasingly shared by all nurses and increasingly well understood. This belief seems to have been amply justified and one finds that many nurses turn eagerly to

written material on supervision. However, our literature in the area of supervision is still scanty. Perhaps before long, experienced supervisors will produce an intensive study of the supervisory process in nursing to which all nurses may turn—both those working in institutions and those who are public health nurses.

Whether they are employed in a health center, in a more isolated rural area, or in an urban agency—official or unofficial—public health nurses work in organizational settings that have certain similarities in personnel. At a minimum, and leaving out for the moment our national and state organizations, community committees, volunteers, and auxiliary workers, we expect to find staff nurses, generalized supervisors, specialized consultants, and administrators. There is no one of us who does not carry out some of the functions of the others in her daily work. The staff nurse gives more direct service to patients and does less administrative work than the supervisor, for example, though each carries out both functions to some extent. However, the main job emphasis is as stated. As each nurse gains security from doing her work well, within the limits imposed by her situation, she is able to see the strength of this professional structure and to turn fearlessly to the appropriate person when she needs help.

If there were no staff nurses, the supervisor, as such, would cease to exist. However, from the point of view of organization, it seems true that the generalized supervisor in public health nursing is in the key position, needing and deserving all the recognition and strengthening that the organization of public health nursing in general and of her own agency can give her.

It is never easy to define the unique aspects of any area of professional responsibility. However, a committee of nurses in the Division of Nursing Education at Teachers College, Columbia University, has attempted to describe the special functions of the generalized supervisor in somewhat the following terms: She is the liaison person between administrators and the staff nurse with regard to the daily nursing service. The administrator, now often with the aid of the whole staff as well as of boards and committees, formulates policies; the staff nurse carries them out in service to the patient. In the middle is the generalized supervisor, interpreting these policies further to the staff, and later,

on the basis of information derived from her observation of and discussion with staff members, bringing back to the administrator a report of the way these policies are working.

The generalized supervisor has an administrative function in her own right. She must take a broad look at the district or area for which she has responsibility and must fit special problems or conditions into the total picture; she must dovetail nursing service, glimpse opportunities or deficiencies in the total situation, coordinate what she sees, and act upon it. It is a well-recognized fact that some generalized supervisors are given such large assignments, requiring so much "paper work," that it is almost impossible for them to keep in close touch with nurses in the field or to have sufficient creative energy left to see opportunities for developing nursing service further. Some of this results from the fact that administrators—usually not nurse-administrators—and governing groups may not appreciate and utilize the true function of the generalized public health nursing supervisor.

The generalized supervisor, unlike the administrator but like many educational directors, maintains her bedside skills or other means of direct service to the patient at a high level since it is she who must evaluate these skills in the work of the staff nurse, and help her or even substitute for her, should the need arise. Also she must be able to judge as accurately as possible what a nursing situation demands of the staff nurse in the way of procedures. Administrators do not enjoy losing their direct nursing skills but usually must accept the hard fact that their job makes this inevitable; on the other hand, maintenance of such skills is part of the generalized supervisor's responsibility.

Even when an agency employs an educational director and in addition one or more specialized consultants, the generalized supervisor is a teacher of new staff, possibly of students, and a consultant-teacher to old staff. She teaches individual nurses and groups of nurses, and therefore must develop teaching skills appropriate for use with the individual and with groups. She carries more responsibility for teaching than the administrator, but no more than the staff nurse does. However, in contrast to the staff nurse, she teaches those who teach the patient. The generalized supervisor is the logical liaison person between the specialized consultant and the staff nurse and in this area has both a

learning and a teaching role. This seems to be true even when the specialized consultant is employed by the agency and is easily available to the staff nurse for detailed help. It is more obviously true when the specialized consultant is employed on a county, state, or area basis. Without her contact with the generalized supervisor, who is aware of the total situation, the work of the specialized consultant becomes limited and spotty and has much less chance of being useful to the entire group of nurses, or of affecting methods and policies.

The situation in which the generalized supervisor carries out her administration and teaching functions is unique in the organizational setup, and as such makes her extremely valuable, or potentially so, to public health nursing service. Because she has the liaison activities previously mentioned and because she consistently spends more time with staff nurses than does any other person in the organization, she is the focus of face-to-face agency relationships. In the urban agency, the supervisor is always there. In the rural agency she is either "there" or available, or should be available. Her influence and the attitudes of her staff interact closely and continuously. Granted an administratively workable setup, the necessary elements for professional growth are in her hands as far as the possibilities for helpful relationships are concerned.

The following paragraph from the report of the previously mentioned committee on supervision at Teachers College summarizes this discussion of supervisory function and states a philosophy of supervision acceptable to many nurses, though by no means to all members of the nursing profession:

The supervisory function consists of administration; of teaching in the broad sense of communication as well as in more structured situations both with individual nurses and with groups; and of unique contribution to nursing service through sustained, immediate contact with students and staff. Productive use of this sustained, immediate contact implies current ability as a practitioner on the part of the supervisor; skill in evaluation of and leadership in the immediate situation; and technical knowledge of, and purposefully used skills in, interpersonal relations which lead to professional growth and improved nursing practice on the part of those supervised. This productive, on-going use of the relationship between the supervisors and supervisor and staff is termed "supervisory process."

This will be amplified by discussion of the work of the supervisor and the young staff nurse, and subsequently of the work of the supervisor and the more experienced staff nurse.

The purpose in discussing the introduction of the new nurse is not to attempt to define the public health nursing material that might be placed before her in class or in other ways, but to suggest attitudes that may affect her use of this material and her ability to become her supervisor's co-worker. For the sake of discussion, it is assumed that the new nurse, even though she is a graduate nurse, is not a seasoned worker from another locality and is not working at top professional level at the beginning of her relationship with her supervisor.

Some of her pre-professional attitudes hamper rather than help her. Since the undergraduate nurse at first normally places her working relationships on a personal rather than a professional basis, she unconsciously endows the hospital supervisor with some of the qualities of her mother, and responds to the supervisor as she did to her mother or perhaps to a former teacher or an older sister. Because she has established these ways of reacting, the nurse comes to her new job with the attitude toward supervisors that she had on leaving the hospital. Her hospital supervisors may have given her skillful guidance but the hospital situation in itself necessitates a strictly regulated staff organization. As a student nurse, she may have learned to obey the supervisor rather than to work with her. Sometimes she has learned to fear the supervisor; sometimes she has learned to depend too much on her. Whatever her experience, she comes to the organization carrying some of her undergraduate attitudes even if she has had field work during a public health nursing course.

Ideally, the new staff nurse is now slowly inducted into the work of the district she will cover. She is given enough responsibility to make her realize that she is of value to the organization, though she is given more direct help than will be necessary later. However, she is confused because, perhaps for the first time, she is learning to be an administrator, juggling a time schedule which includes clinics, conferences, home visits, classes, and conferences for herself. If



work. She was mentally quick. However, although she did skilled bedside nursing and had administrative ability, little of her own color and alertness seemed to carry over into her daily work. She showed no interest in having students assigned to her district. In conference and during round table discussions her attentiveness was obviously assumed or she actually carried on sly monkeyshines like a child in school. Unlike the majority of the staff, she seemed to gain nothing from these group discussions that she could apply to her work. Off duty, however, she was a different person — a delightful individual. It was then that she made use of her originality. The picture seemed complete when, for a staff party, she wrote and staged a skit in which the finer points of public health nursing that so rarely appeared in her work were accurately introduced and amusingly caricatured. Here was a capable nurse who, for reasons we do not know, had never become a professional worker. Perhaps she was carrying over from childhood into her relations with other workers, especially with supervisors, her early feeling about learning situations.

If the agency staff is able to achieve true professional status and if its policies offer the incentive of an immediate opportunity to apply in the community what is worked out in the office, it seems that the *directive* concept of supervision will be slowly displaced by one more appropriate to professional practice and learning. Supervision is now thought of as a relationship between supervisor and staff nurse that is founded on a common interest in the point of view of each. Not all the opinions expressed in conference by field nurse and supervisor will be practical or even in accord with known facts. However, the expression and consideration of them by these nurses make the decisions that are ultimately reached more acceptable to both, better understood, and so easier to carry out. This is not to say that the young field nurse — or any field nurse — is helped by being obliged to meet opposing philosophies of supervision in the same agency. But varying, even opposing, points of view do not necessarily imply opposing philosophies; they may be based on a fundamental accord.

Occasionally an order must be given to the nurse by her supervisor and obeyed instantly. However, the order and the carrying out of it are not in the "you're in the army now" spirit. An order to the nurse transcends mere regulation by a person in authority

since it is the situation itself that orders supervisor as well as nurse. This inescapable demand of circumstances operates also in family relationships. The child grows to realize that circumstances, not merely his mother or father, make demands upon him and that these circumstances make demands upon his parents as well. It is often found that many emergencies are not actually crises when they are examined further, and the supervisor may realize later that her authoritative order was not necessary.

Ideally, the young nurse sees the group process in operation in morning round tables when the day's work is planned or new situations are introduced; in staff councils; in supervisors' meetings; in staff educational projects. As a matter of fact, if the field nurse is to be expected to use with her patients in the community the concepts and techniques of group work, it seems logical that she should learn these techniques "at home," as they are practiced by the members of her own agency or profession. Probably the methods she will use in working with groups will be those she observes and practices daily in her own agency.

As the generalized supervisor carries out her function of consultant-teacher with the "older," established staff nurse, she finds, ideally and increasingly, that the relationship has become work-centered and that it is a shared, "two-heads-are-better-than-one" experience. With this as the expectation, possibly even the norm, the work of the supervisor has two main emphases.

The first of these, and the one that claims most of the supervisor's attention, is the job of implementing the work of experienced nurses by consistent administrative backing, by such leadership as the nurse may need in giving nursing service, and by helping the staff to obtain additional skills and information that will be useful in their work. She grows in her understanding of differences in personality and of individual ways of working. She accepts the fact that all the staff must normally be dependent on her in some measure. She understands that although the experienced nurse has often succeeded in working out her personal problems or has found a way of living along with them, some reflection of them may appear in her work and in her attitude toward supervision. The supervisor understands that this will be true of herself,

too, and therefore tries to be aware of the meaning of her own behavior.

Second, the supervisor is faced with the task of meeting constructively the problem situations that arise — the departures from the expected norm. Some of these are situational and mainly administrative and have to do with the difficulties of budget, program, and complicated or frustrating community organization. Many problems grow out of individual difficulties on the part of staff, which cause discomfort to supervisor and staff nurse alike and which endanger good nursing service. It is the supervisor's task to see these problems more objectively — in a way that the nurse who is immediately involved in them cannot. This is not easy, for the supervisor, too, is always involved in the nursing service within her territory.

Most of us will recognize as typical the following problems raised in one discussion group:

1. At what point do personal problems and anxieties of staff members go beyond the stage when the supervisor should alone be the recipient, and when does it become her responsibility to divulge confidential issues to the executive director? If the staff member is firm in her desire not to have the situation divulged, to whom does the supervisor owe allegiance, the staff nurse or the executive director?
2. How can a supervisor help to include the nurse in group activities? This refers to the nurse who is an isolationist and seldom, if ever, a joiner. Should she be left alone or is other help indicated to get at the reasons for this behavior?
3. How can a supervisor help a nurse see that she needs assistance with her own emotional or social problems?
4. What is the best way to work with the nurse who is regularly late?

Some discussion of the supervisor's attitudes toward such typical problems may be appropriate here.

It is the supervisor's immediate responsibility to work constructively with the staff nurse who exhibits acutely or persistently difficult behavior problems; and in carrying out this duty she can never hope to avoid uncomfortable situations, sometimes even painful or frightening ones. Such situations may seem to emphasize the authority of the administrative part of the supervisory function; they call for skills in interpersonal relationships that

the supervisor may feel she does not possess in adequate degree. She would prefer to identify as far as possible with her staff nurses, but now she must seem different from them. She shrinks from causing pain, from intruding, and she wonders if she is "right" in what she sees. The supervisor customarily teaches the nurse that the patient is resilient, that he usually has strengths on which the nurse may help him build. But it is easy to forget this when the other person is another nurse rather than a patient. The supervisor may forget, too, that she does not have to "reach into the blue" for a solution to this problem but can, as always, safely rely on a problem-solving approach to the situation.

This approach is based on our generally accepted assumption that all the supervisor's thinking, planning, and effort are work-centered or, in other words, centered on the service or patient. This assumption in itself often clears away some of the supervisor's doubt about procedure. What is the effect of a given situation on the patient, his family, the nursing service of the agency in general? Probably we should agree that our common interest in the helpfulness of the nursing service gives us our only justifiable basis for questioning one another's attitudes and reactions, here especially the behavior of a staff nurse. If we accept the wide range of the "normal," the only dependable basis for questioning any behavior on the part of a nurse must be evidence that nursing service is suffering or is endangered, apparently because of her behavior.

Focusing on the nursing service in this way, we see more clearly what is involved in the first and second problems previously listed. In the first instance, the "allegiance" of the supervisor is not to the staff nurse on the one hand, or to the executive on the other, but to the nursing service. In other words, her efforts are work-centered. At what point will irremediable harm be done to the work under the given conditions? In the case of the nurse who is never a "joiner," is this so disturbing to the nurse herself and to other members of the staff that the work is suffering; and if it is not, should supervisor and staff alike be more accepting of the diversity of "normal" behavior? Over and over again it has been shown that the supervisor whose approach to problems is consistently work-centered earns the respect and trust of staff and administrator alike.

The problem-solving approach in itself is a reassurance to the supervisor because she can rely on method as a means for reaching a reasonable conclusion rather than feeling the necessity for arriving at once at a solution of the problem that faces her. In an emergency the supervisor uses the best judgment she can muster; in difficult situations of longer duration she uses a method of approach that she can review when she wishes to do so and that she can describe to others.

We realize the advisability of approaching any established problem first by study of the broad factors that underlie it, and only later by consideration of specific details. In this way we have an opportunity to understand the problem as a whole and to see the cause-and-effect relationship more clearly. If the supervisor approaches a problem more superficially, studying only its immediate symptoms, she finds that she can merely suggest alternative possible causal factors and that she has no real basis for deciding that one or another or a combination of them is really at the root of the difficulty.

The fourth problem on the previous list — the nurse who is always late — is a case in point. The supervisor knows that there may be a general psychological interpretation for behavior of this kind, which may not apply to this situation but which she certainly must consider. A departure from generally accepted agency policy may be a form of rebellion, whether or not the individual is conscious that this is the basis for her behavior. Perhaps the nurse has not yet worked through successfully the typical adolescent reaction that impels her to rebel against anyone or any situation that seems authoritative, even though the regulations imposed by the reality situation may be justifiable. In such a case one can see how family patterns of childhood may be re-created and how the supervisor may represent mother, teacher, or previous supervisor. Other staff members may represent a still unresolved rivalry situation as it existed between siblings or schoolmates. In this instance the staff nurses who arrive punctually are, perhaps, the "good" siblings.

Furthermore, the supervisor knows that cultural patterns always influence the individual, and she will want to determine the degree to which this is true in the tardy nurse's case. The nurse may come from a family that paid little attention to time

and in which family routine was kept to a minimum. It may be that she is continuing this pattern, or the exact opposite may be true. Her family may have adhered so rigidly to a time schedule that the nurse now wants to throw overboard her family traditions.

Environmental factors are no more real than the deeper causes just discussed but are admittedly easier to discover and evaluate. It is possible that the nurse has changed her living arrangements so that she is farther away from the health center and has not yet adjusted her transportation problem adequately. She may be battling with an early morning schedule which involves leaving her child at a nursery school or giving nursing care to a parent before leaving for work. The health and vitality of the nurse also must be considered, both in general and with regard to fluctuations and recent changes.

Still maintaining a broad approach but now trying to learn in as sound a way as possible if the nurse's habit of being late is the symptom of a deep-seated, difficult problem or is more superficial and therefore more easily met, the supervisor turns to a study of the work of this nurse as a whole. Here, if she has been enabled to undertake her full role as supervisor, she finds the tools at hand. They are the same tools that she customarily uses in carrying out the consultant-teacher aspect of her function.

The supervisor turns to the nurse's records, to her own notes on previous conferences with her, and, with as much objectivity as possible, to her observations of the nurse's behavior in general. If the nurse has had the opportunity to write full records, and if the supervisor has been able to compile a cumulative record of her knowledge of the nurse, including anecdotes that are characteristic, she has much of the data she needs for a well-founded answer to such necessary questions as the following: Is an immature rebellion evident in all other aspects of this nurse's work? Is it evident in some of them? Is lateness the only evidence of it? Is this habitual lateness increasing; how recent is it; does it fluctuate, and if so, does it correlate with other known parts of the situation? All of us show our characteristic reactions and methods in our records, our conferences, and in daily ways of behaving. Having considered these questions, the supervisor has a rational basis for her thinking and is ready for further conference with the

nurse. One cannot say what will happen in the conference any more than one can "structure" any interview in advance. But the supervisor will listen, observe, and respond, giving her explanation of the way the situation looks to her with real respect for the nurse with whom she is talking.

All this presupposes that the supervisor has herself reached the level of professional maturity—a level of development that we all reach and maintain with some difficulty—and that she has awareness of or even insight into her own characteristics. Suppose, in this instance, that the supervisor is very time-conscious. Perhaps she has been brought up in a household in which meals and other activities always took place "on the dot"; perhaps she has some tensions of her own that cause her to look at her watch many times a day, even when it is not necessary for her to know the exact time. It would be hard for her not to be especially tried by a nurse's apparently calm obliviousness to a time schedule.

Thus we come back again to the basic necessity for understanding ourselves. We saw this necessity in the case of the nurse who works with individual patients and with groups of patients. Here we see it underlying and implementing our relationships with co-workers.

If supervision is available in its most constructive form to the staff nurse, she is helped to realize the ways in which her attitudes and methods influence her work. However, although the majority of supervisors are quite aware of their responsibilities, the question is often asked—sometimes rather desperately—*who helps the supervisors?*

Some of this help comes from the policy of the agency where the supervisor is employed—providing it gives her both support and freedom in planning and discussion. Some help is coming increasingly from workshops and conferences where the supervisory process itself is discussed and where supervisors become acquainted with each other, and can discuss common problems of administration, teaching, and nursing service. Some help must come, more rapidly than is now the case, from university centers, where it should be possible more and more to give the generalized supervisor additional knowledge and experience in working with people without requiring her to specialize in mental hygiene. There is a growing, legitimate demand on the part of supervisors

for such additional preparation. Field work appropriate for this is difficult to plan and implement at the present time, but it should be regarded as a pressing university problem.

Many supervisors have an intuitive grasp of their function and have worked ably without the added security and ease that special preparation for this position could give them. However, we recognize that the successful staff nurse is not necessarily the successful supervisor. Social workers consider that the function of supervision is a specialty. In an article describing the growth process that underlies social casework practice Dr. Jessie Taft says, "casework skill cannot be transformed into supervisory skill, nor can caseworker responsibility be equated with supervisory responsibility, without an intervening developmental process."<sup>9</sup> In public health nursing we are attempting to strengthen the "intervening developmental process" by providing in-service training for the senior guide who accepts responsibility for students and sometimes for young nurses; by seeking better ways for orienting the supervisor who is new to her function or new to the agency; and by strengthening our university offerings.

It was stated previously that supervision is a "process." This is perhaps most clearly seen in the supervisor's work with the young nurse. However, one also sees a growth in relationship between supervisor and each individual staff nurse, if the relationship goes well. There are insights that the supervisor can acquire and use that lead to a successful relationship — and ultimately to the easy dovetailing of the tasks of two professional workers, each of whom knows her job.

Some of these insights go beyond the supervisor's partial knowledge of her own individual characteristics. She may find it useful, for instance, to recognize and maintain the "difference" between herself and the staff nurse. All of us are responsible to some individual. It would be a demoralizing experience if we found that this individual — perhaps our director — was merely one of ourselves. We may be as skilled in our roles as she is in hers, but we need her in the role that she has been employed to fill. She herself might be much more comfortable if she could deny this difference; in some instances, out of the sheer discomfort that comes from being so definitely in the minority, supervisors have actually "abdicated." A comparison between this situation and the pattern



of family life occasionally seen some years ago may not be inappropriate. One remembers a time when parents sometimes tried to make themselves merely the playmates of their children, probably in an effort to escape the responsibilities of authority and the hostility that in varying degrees is part of the growth of personality. Parents found that this did not succeed because, inevitably, parents are not children — they have a different role to play. Similarly, supervisor and nurse have different roles, but here the difference is a matter of professional responsibility and has less to do with behavior or manner, socialization with staff, and the like, than we always realize.

Probably the supervisor must always bear the burden of evaluating the work of others, along with the occasional discomfort attendant on this responsibility. Discomfort persists even though the staff nurse shares in the evaluation of her work. Current practice is steadily confirming the value of the plan that both staff nurse and supervisor shall contribute to the process of evaluation. There are obvious and lasting strengths in this cooperation. However, in the last analysis, the supervisor has an administrative function in this connection which, while it need in no sense make the shared evaluation artificial or a mere gesture, means that the staff nurse must always experience some fear of the supervisor's judgment. It seems safer for the staff nurse to realize the truth of this and be guided accordingly than to fail to recognize it. The same would be true of all employed people. It is true of the supervisor.

It has been said that generalized supervisors are focal points for relationships within the agency. Miss Robinson cites as part of the professional worker's equipment, in addition to knowledge and skills, "the controlled use of the capacity to relate oneself and one's service to people."<sup>83</sup> Thus, the supervisor, recognizing the various projections and identifications of those with whom she works and knowing that her relationship with her co-workers is not a casual one, is aware of the way in which she uses herself with others. Even though, like most nurses, she wants to lessen the discomfort of others, she realizes that an indiscriminate "comforting" or protection of a nurse, inappropriate to the reality situation, is not helpful in the long run. She continues to accept the nurse but helps her to see her situation more clearly. The supervisor's interest in the individual nurse and her desire to help

her are very real. However, in order not to foster dependency in the nurse she is not available to her at all times, but only when the situation warrants it. By placing reasonable limits on the time and the number of contacts, she encourages the nurse to consider and formulate the situations that she wishes to discuss, so that conference periods are well used.

This means that the supervisor keeps her appointment schedule of conferences with the nurse meticulously, so that the nurse may have the security of knowing that a certain time is hers and can center her work with the supervisor in this conference period. Gradually the nurse takes the lead in such conferences. As this becomes an accustomed process, the supervisor finds that she herself need introduce fewer of the topics she has in mind as advisable to discuss. Many of them will fit naturally into what the nurse is saying. If the relationship is a helpful one, the nurse reorganizes her thinking and gains perspective as she talks to the supervisor, even though the latter, thinking and observing as she listens, says very little. Gradually, the nurse becomes identified with the supervisor. In this way, what she knows the latter would say if she spoke and what she has said in previous conferences become a part of her own thinking in the present conference and are incorporated into her remarks and, later, into her actions. If the supervisor, at an appropriate point, can contribute information based on her experience or on her knowledge of the broader community situation, she does so. This may add to or modify the nurse's picture of the situation. In the same way, the nurse's intimate knowledge of local factors may lead her to suggest changes in or to criticize constructively a general policy in which the supervisor is interested. When she does so, the supervisor does not defend her policy but tries to re-evaluate it realistically. The supervisor, too, states her point of view, and this does not necessarily agree with the thinking of the nurse. Again if the relationship is a helpful one, the nurse has the security of knowing that if what she is saying is not accepted at the time, it does not mean that she is rejected as a person or that her thinking and work in general are undervalued, but only that the situation under discussion is open to question. We realize that the nurse is best able to outgrow her weaknesses as she gains security in using her strengths.

The supervisor accepts as part of her role a certain amount

of hostility and rejection on the part of nurses with whom she works. Some hostility is inherent in the continued growth of the nurse. New experiences and new information make inroads on her personality, causing her some discomfort. Frequently the supervisor seems to her to be the source of this discomfort. Or, in her administrative capacity, the supervisor may be identified by the nurse with an agency policy that she has not accepted, and may be seen wholly, if temporarily, in this light. Most people want to be liked by others and feel uncertain, unhappy, or angry when faced by even temporary hostility. A child will give away his best toys in order to be better liked by indifferent playmates. It is understandably difficult for a supervisor to accept hostility and to guard against the desire to retaliate or the feeling that she is inadequate.

Some nurses, whether or not they are supervisors, face a different and more acute kind of hostility. The employment situation in an agency, complicated by extreme personality difficulties, may be such that a lasting, harmful, negative relationship exists between two members of the staff. Perhaps a promotion has occurred that is, or is thought to be, unfair. Perhaps a new supervisor or director has been brought in "from the outside" when promotion to this position was expected by a nurse already employed by the agency, an expectation that may or may not have been warranted. Sometimes such situations can be worked out successfully, if one has enduring patience and good insight; sometimes they are untenable and one of the nurses leaves the agency. A number of us can cite instances in which careful consideration on the part of administrators who were aware of emotional values could have prevented similar difficult situations.

The attitude and method of working of the administrator or administrative group permeates the public health nursing organization. The attitude and methods of generalized supervisors influence the daily work of the nursing staff in an even more specific way. We all need opportunity to grow through identification. The kind of conference the staff nurse has with her supervisor influences the way the nurse works in her interview with patient and family. Even if the staff nurse has had excellent academic courses that help her to understand the dynamics of human behavior, her field work may not always show her these

concepts and methods in action. Whether or not she has access to academic courses, some of the nurse's best understanding of herself and others will be gained from her work experience. Public health nurses are increasingly aware of this. They realize that we must strengthen by every known resource the professional position of generalized supervisors and in this way foster their growing ability to carry out a helpful supervisory process.

## »» PART II ««

### *Interagency and Interprofessional Relationships*

In many communities, urban and rural, each public health nurse functions in a network of relationships with nurses employed by other community organizations and with members of other professional groups such as health educators, teachers, and social workers. Increasingly she finds herself closely associated with the latter. At times she seems caught in a hampering entanglement of red tape. On the whole, however, she realizes that such relationships form a network not unlike a great radio system. They have become a much-needed means of communication now that community organizations serve a more varied group of persons than formerly. They are also an essential basis for interaction between different agencies. We recognize that well-planned programs are productive and economical; that even an emergency is not an isolated circumstance but one that is related to the events leading to it and to the circumstances that may result from it.

### JOINT PLANNING

The coordinated programs now carried on by the various community agencies require more concerted planning than the old type of service. As a part of this program of coordination, directors and workers in national, state, and local public health nursing programs have become highly self-conscious, in the sense that they study what they themselves are doing or ought to be doing and also in that they are aware of the need to dovetail resources, and of what allied professions are doing. The Council of Social Agencies, with its *Social Service Index*, now state-wide in some

instances, and its customary subdivisions for health, family case work, and child welfare, is often the headquarters for this community planning. The visualization and, in a few cases, the establishment of health centers uniting all health services, both those within and those outside the hospital, in a closely coordinated functioning unit, with whatever realignment of activities is necessary and with inclusion of auxiliary personnel, is an outstanding example of such merging of professional activities in the field of health.

Even in the small basic unit of the local community, joint planning is not invariably effective in spite of efforts to that end. Difficulties are sometimes caused by unsatisfactory policies that are residuals of a former day, by lack of community planning influenced by dearth of funds and personnel, or by a misinterpretation of their special function on the part of individual nurses or other professional workers.

The following is a familiar instance of the difficulty that is sometimes caused by lack of thorough, coordinated planning. A dispensary clinic for the treatment of syphilitic patients had used for some years the field nurses of the local visiting nurse association to trace patients and to attempt to persuade them to return for treatment. Some of the patients were members of families known to the nursing association. Others were strangers to the visiting nurses, whose first contact with them had to be made on this negative basis. The goal of both clinic and nursing agency was to lessen the damage from syphilis in the community and to safeguard these particular patients. The plan of follow-up was in this case a failure. It failed because it was not part of the function of the visiting nurses in this community, who were still administratively entirely separate from the venereal disease clinic, to visit the clinic's patients, many of whom they did not know and whose contact in many cases had been with another health agency.

The following material from an address given some years ago by Dr. Mayhew Derryherry is not so generally applicable today as it was at that time. Nevertheless, it still warrants inclusion here. Dr. Derryherry is discussing the effect of uncoordinated health activities on the work of the nurse.<sup>22</sup>

I should like to mention briefly one or two administrative procedures that limit the effectiveness of the nurse as a family teacher. . . . The first of these

factors is the lack of coordination between clinic and field service. In a well-organized service the nurse presumably coordinates her teaching in the home with the findings in the clinic. To do this there must be some administrative machinery by which the nurse is informed of the findings in the clinic.

He then cites a nurse's visit to an antepartum patient in which she advised the patient, in accordance with standing orders, to increase her fluid intake. The nurse was unaware until the patient questioned her advice that increased fluid intake had been found at antepartum clinic to be contraindicated for this patient.

The nurse had no means of knowing what the physician had found. Such situations tear down the patient's confidence in the advice given her by either the doctor or the nurse and sometimes both. Unfortunately, such lack of coordination exists all too frequently.

A second way in which the effectiveness of the nurse's teaching is hindered is the failure of the clinics to deliver the type of service she describes. When patients attend clinics at the suggestion of the nurse and find it to be an unpleasant experience they are less inclined to listen to the nurse's advice on other problems. Consider the following in an infant hygiene visit:

Mrs. A: "I went over to the doctor as you told me to do, and he didn't say anything at all about the child's navel, so I asked him . . . so he said, 'I think it's a little ruptured.' I said, 'Well, will you tell me for sure,' and he said, 'I think it is, don't worry about it,' but he never examined the baby's navel at all. *That's one reason why I didn't go back.*"

One may find that somewhat unproductive working relationships still exist between public health nursing organizations in the same community. Like the previous one, this difficulty may be the result of the administrative setup, but its ultimate effect is felt in the relationship of nurse and patient. Several such public health nursing agencies may be working in one area: the "official" agency under the auspices of city, county, or state; the "unofficial" agency supported and administered directly by community residents; a group of nurses employed by the schools; and industrial nurses individually employed by local business concerns. Of these, the "unofficial" agency usually does bedside nursing and may or may not have a broad program of health work in addition. One can observe a trend toward uniting all the programs into a more generalized nursing service. Meanwhile, however, one sees the result of the present division of labor.

Dr. Derryberry also gives an example of the difficulty sometimes created by this administrative severing of bedside nursing from health service:

Nurse (to a patient who has just returned home following a Caesarean):  
"Now, if you don't mind, I will just look at your incision."

(The nurse examines the incision and puts a few questions, and then the patient asks)

Mrs. B: "If the doctor dismisses me from coming to the clinic, how can I get it dressed?"

Nurse: "If you should need it dressed, the visiting nurse could come in and dress it. We don't carry dressings."

Of this partial record of the visit Dr. Derryberry says:

The nurse's reply is perhaps not the one she would have given by choice. But until the policies of the health department are changed, it is the only one she can give. However, it is well to recognize that such situations rob the nurse of her most practical way of interesting clientele in the health advice she has to offer. We all look to those who have helped us out in the past as the ones most likely to be helpful to us in similar situations.

This problem is raised here not to suggest that one should seek immediate merging of nursing agencies, but merely to point out some of the familiar difficulties inherent in the present situation.

With several groups of public health nurses working in a community, it sometimes appears that dividing the program among them separates them more than the setup in itself necessitates. Working under different auspices, housed in separate offices, carrying different parts of nursing responsibility, these groups are nevertheless engaged in public health nursing in the same community. An outstanding example of unwillingness to make use of joint educational facilities was furnished by a city in the eastern part of the country. Here two groups of nurses representing two large community organizations gathered in the same building at the same time, each for a course of lectures on psychology by a different teacher, continuing this procedure over a period of weeks. In spite of examples such as these, joint educational programs are increasing in number and in usefulness.

When one considers the complex individual problems of each agency as it seeks to work out its staff educational program, it seems that a joint program that would try to meet the needs of the official group, the visiting nurses, the school nurses, and nurses working in clinics and dispensaries would perhaps offer more confusion than clarification. Yet in many instances, community problems are important enough to outweigh the needs of the individual agency and, in the minds of an increasing number of nurses, de-

mand concerted attention. The need for such a program is partly met by the regular meetings of state associations of nurses. Even these, however, cannot give consideration to specific local needs. A workable plan for local coordination of staff education projects has been attempted with some success in several large cities. Study groups have been set up that cut across agency and professional boundaries and select their membership on the basis of experience and function. This is in line with the current trend toward bringing together the experience of all professional groups primarily concerned with human behavior.

It is sometimes observable that the visiting nurse association and the official nursing agency working side by side in a community are mutually tolerant in their attitude but may not have succeeded in supplementing each other's services in a practical and thorough way. Under cover of a rather unthinking acceptance of the place of the other agency in the community, there may be a feeling of possessiveness with regard to referral of patients and also a defensiveness about program. The visiting nurse may mask her inner conviction that every nurse should include bedside nursing in her program. The nurse employed by an official agency, whose health teaching may not include bedside nursing, sometimes feels frustrated because she is unable to meet the patient's need in this respect. However, she may look somewhat askance at the hurrying visiting nurse who seems barely to have time to roll down her sleeves between visits to sick patients. Also, she may have the mistaken idea that the visiting nurse association is "wealthy"; she may be unaware of the curtailed budget finally accepted by the board or the community chest. The school nurse, in spite of her attempts to organize her field and to cooperate with other associations, may still seem somewhat separated from the official body of public health nurses in her community. In fact, she often is an employee of the board of education and has no administrative connection with other local nursing services. This dissociation may also characterize the position of industrial nurses who, though they meet among themselves to compare notes, may have few contacts with the larger group of public health nurses in the same area. Yet one realizes that the community nurse and the industrial nurse have common professional problems demanding active cooperation.



It seems doubtful that an unanalyzed attitude of *laissez faire* on the part of public health nursing agencies toward one another is constructive. For this is not a question of the forbearance with which friends regard one another's eccentricities or convictions or the acceptance with which a professional worker regards her patient's ingrained standards, but instead a question of the understanding with which one professional group approaches another so that their combined services may be as useful as possible. The *laissez faire* attitude may be partly the result of the loyalty which logically or illogically characterizes the feeling of nurses for one another. But beyond this many nurses have the feeling that it is well to let each worker wrestle with the problems of her own agency program. This inertia is caused in part by the fact that busy nurses from each agency have found it expedient to learn the policies of other agencies — what each organization can be expected to do and what it cannot do in service to the community — without any real understanding of their functions.

A speaker interested in the effect on the patient of inconsistency in agency policies said in the course of his remarks that it is not the "fault" of the individual field nurse that she must confront her patient with gaps and contradictions in policy. Perhaps the speaker was attempting to reassure the field nurse in whose taxing work these and many other problems come to a head. However, while it is obvious that the field nurse cannot actually direct agency policy, she can perhaps take the lead in suggesting possible changes because it is she who first sees the effect of the administrative plan in the field. She can, if she is aware of the importance of her reactions to the policies of her own and other health agencies, be instrumental in modifying or developing the plan of action. This could be stated more strongly by saying that a professional worker inevitably accepts this responsibility, and that a democratic administrator welcomes and, in fact, expects her participation.

In an earlier chapter it was suggested that it was important to the nurse to be aware of her reactions to her patients. In the same way her emotional reactions to her work as a whole — her pleasure in it or her dread of certain aspects of it — may be useful signposts, indicating that she is carrying out her function easily and well, or that she does not understand certain parts of her work, or that these activities have been poorly planned by the agency. If a nurse

dreads a return visit, perhaps she has had an unpleasant experience in that home or perhaps a situation exists there that she does not know how to meet and in connection with which she has not fully considered what her agency has to offer; perhaps, however, she does not understand or has special reason to be dissatisfied with the plan, based on agency policy, under which she is entering the home.

It is at this point that supervisory conferences and field visits may be especially helpful, since the supervisor may have a broader understanding of agency function and policies as a whole and can help the field nurse to evaluate her reactions and to discover whether her difficulties are her own or are founded on an unworkable agency or community setup.

Cooperative relationships cannot be established and fostered by the efforts of directors or coordinating health councils alone. At present it seems true that many public health nurses accept the community setup under which they work as more or less inevitable. Actually, their participation is needed in planning and in evaluating the way in which policies work out in daily use. Sometimes nurses are more tolerant of one another's difficulties than creative in finding better ways of cooperating.

It is sometimes amusing — if one assumes the "role of the laughing third" — to see how difficulties among nursing agencies are forgotten when the group as a whole considers its relation to other professional groups in the community. That logical or illogical "loyalty" previously mentioned becomes apparent, and in it one senses an element of defensiveness, a feeling that a united front might on the whole be best and safest when community planning is undertaken. Perhaps a discussion of the relationship of the public health nurse and the social worker — primarily the family case worker — may give the essence of this situation.

An old misunderstanding — or lack of understanding — has existed between nurses and social workers, both as professional groups and as individual workers. A nurse with whom this subject was discussed recently said, "But don't you think that feeling is now in the past?" Experience answers that at least some of this feeling still remains. However, we are attempting to understand one another and one another's function in the community, and we have made considerable progress in this direction.

It may be that nurses and social workers will never see things

from exactly the same point of view. It does not seem necessary that we should think entirely alike. A certain amount of difference may be stimulating as well as inevitable. However, most nurses and social workers would agree that we still have progress to make before we reach the point where we can consistently use our difference to advantage.

### FORMULATION OF FUNCTION

It is undeniably helpful in working out relationships with other professional groups to be able to rely on a formulated concept of public health nursing function, since agency policies and programs are based on function. However, because of the progress that has been made in understanding human behavior and the resulting trend toward the acceptance of common professional concepts, a clear-cut definition of function is no longer easy for any one profession to achieve. Such a definition cannot be really specific unless two goals have been successfully reached: first, one must be able to say that a certain area or function, and therefore activities immediately attendant on it, belong uniquely to a given profession; second, one must be able to define boundary lines between this profession and the others.

Time was when we thought the second of these two goals to be more important and took the first more or less for granted. We had, perhaps, a mental picture of professional relationships which, in clarity of boundary lines, resembled a map of the United States. And we defended those boundaries. We are more realistic now because we understand that a patient or client must be seen "whole," and because we are more willing that in these areas differentiation and activity be worked out as appropriate. This means that the adjustment may be somewhat different in various localities and as individual nurses and other professional workers plan their cooperation.

However, at the present time each professional group continues to need to define what it has that is unique — the nucleus of its reason for being a distinct profession. The suggestion is offered that although some of this need is realistic, some of it may be defensive and possessive. It might be possible to agree that, while some uniqueness of function must remain, some might well be

seen rather as a logical and legitimate professional *emphasis*, resulting from and dependent on that part of the function which really is unique. Both in carrying out the unique part of the function in a given profession and in carrying out its resulting professional emphases, the workers in that profession acquire a high degree of skill, a skill which, while it may to some degree be possessed in common with certain other professional groups, is characteristic in its full development of one professional group. To this extent, the skill in carrying out the derived function becomes in turn unique to a profession — in our culture. Whether or not it is important that similar professional groups work in the same way and have the same defined purpose the world over would be beyond saying here. As international organizations become established, one might say that this would tend to be necessary. On the other hand, we accept many cultural differences easily enough. One thinks, for example, of a country in which the public health nurse and the social worker in the community are one and the same person — a practice certainly different from our own.

Historically and uniquely the nurse supplies consistent, skilled, personal service to the sick person — service related to his illness and supplementary to medical diagnosis and therapy. She does this in order that the patient may return to or achieve the best state of health possible for him, may be aided to do so as rapidly as possible, or may have the benefit of such care during a terminal illness. This part of the nurse's function, and the high degree of skill developed in connection with it, belongs distinctively to the nurse and is not shared with any other professional group. In the course of this service to the patient, the nurse inevitably sees not only signs and symptoms of illness, discomfort, and deterioration, but also signs of returning health, of special strengths that enable the individual to return to health, and evidences of growth and of factors that contribute to it. Even though a nurse eventually decides to do her work in a setting of direct health promotion rather than in a therapeutic setting such as the hospital ward, she comes to this through experience of that intimacy with people which results from knowing and giving care to their bodies. To the nurse, the body and its physiology are tremendously important; they are also very important to any individual, be he sick or well. We realize that many individuals make extraordinary con-

tributions and successes in spite of illness and physical handicap — but against what odds, and at what cost!

One often bears the comment, "The nurse has a ready entree into the home" or "to the patient." Sometimes members of other professions react to this comment with some resentment because they realize that their relationship with a client may also be intensive and very welcome to him. Nevertheless, the feeling the sick patient has for the nurse is special in that it is related to childhood experiences of nurture, of release from physical pain, of attention to small and great needs that sometimes were emergencies. The intimacy of the relation, while retaining some of its childlike aspects, can be handled on a more conscious level by nurse and adult patient, and remains the most significant source of strength that the nurse has in her health work.

Therefore, one might say that the unique function of the nurse is nursing care to the sick or physically incapacitated person and that even her derived emphasis remains primarily the physical — the body — as she shares in common with other professional groups the knowledge that the cultural and emotional environment are inherent aspects of all bodily response, and that growth and development can only be understood and fostered on a psychosomatic basis. If this emphasis seems earth-bound and limiting, one can also remember that the psyche and the soma interrelate in both directions, and that man's mind has not yet fathomed all the subtleties of human physiology.

It seems possible that a conscious or unconscious acceptance of this idea underlies the partial resistance that some nurses show to the report prepared by Esther Brown on nursing for the future,<sup>22</sup> which, emphasizing as it must the necessity for auxiliary workers, seems to remove the professional nurse farther from the patient. Nurses say that one is only able to know and to help the sick patient as one gives him nursing care, and watches him and listens to him at such times. Fundamentally, perhaps we fear that we shall lose our unique function. Study of the personnel and activities of nursing teams is continuing on a sound research basis, and one begins to feel considerable assurance that her unique function — if it is here described at all accurately — will not be lost to the professional nurse.

If there is any validity in the above, the public health nurse

who does not include a bedside program in her activities is carrying out a "derived emphasis," but is not fulfilling the original and unique nursing function for which, in our culture, only the nurse is equipped. A foundation for her customarily good contact with patients in the community has been suggested. Her skill in recognizing health and illness, while it is not diagnostic in the medical sense, is characteristically perceptive and accurate beyond the point that any group of professionals could reach who had not experienced years of the kind of intimate association with the patient previously described. Perhaps this serves in part to make the necessary distinction between the work of the nurse and that of the health educator or medical social worker, with both of whom she has much in common.

Two outstanding skills might be said to characterize the capable social worker. One of these is skill in interviewing; the other is the development and use of the supervisory process and the ability to teach it. The second of these skills can perhaps be fully adapted to the use of other professional groups. Knowledge of the dynamics of human behavior, of group life and cultural patterns and trends, is increasingly common to a number of professions. Since such professions may make use of this knowledge in careful work with individuals and families, it seems logical to say that such groups, including nurses — here especially public health nurses — are doing "case work," but not "social case work," a term that arises from and belongs to the function of the social worker.

If we accept, at any rate for purposes of discussion, the previous suggestion as to the unique and derived functions of the nurse, it is then possible to review in accustomed terms some of her related purposes and activities. These she carries out in common with other professional groups and to the degree that her basic purpose, plus the presence or absence of other community resources, indicate. It is in these areas that considerable misunderstanding still arises between professional groups in the community.

The nurse has an educational function, related as far as possible to the family as the unit. She also has a protective function, doing her share in the carrying out of public health laws relative to communicable disease, protection of water supply, management of housing problems, and the safeguarding of children.

MUTUAL AWARENESS OF  
PROFESSIONAL FUNCTION

If the nurse can be said to have a nurturing role centering in her unique function and its derived emphases, other professional groups also have this role in their own fields of work. For example, social work agencies provide when needed the necessities of life such as food, shelter, warmth, or the money to buy these. Family casework agencies take the family as their unit of work. Social work agencies also have an educational function though they might not wish to define it in these terms and might prefer to say only that they are attempting to help individuals and families to find their own ways to better living. A number of social work agencies and other groups have a protective purpose. It is no wonder then, that when it has not been possible to plan and think together, nurses, social workers, and other professional workers sometimes invade each other's territory, usually unaware that they have done so.

For example, a number of public health nursing agencies, while stating that it is not a nursing function to give relief, continue to do so in traditional ways that are not recognized as relief giving. A nursing organization may have a cache of blankets, bathrobes, or other sickroom supplies that a special fund or contributor maintains for distribution to "needy" patients. In giving out these supplies, the organization may overlook the fact that these patients are known to family casework or relief agencies, and may never have discussed the larger question whether these supplies ever should be distributed by a nursing organization as work is now organized.

Another such traditional activity carried on by various public health nursing agencies is the distribution of Thanksgiving and Christmas gifts in the form of baskets of food or boxes of clothing and toys. Even if this activity is carried on as cooperatively as possible, with families carefully "cleared" with other agencies or through the social service exchange before gifts are presented, the nursing agency may nevertheless be said to be confusing the issue of relief giving in the minds of both donors and patients, and to be tangling agency relationships still further. Similar activity on a smaller scale may continue the year round. A member of

*the community who is especially interested in mothers and babies presents layettes to the nursing organization for distribution. A family who is purchasing a new stove wishes to present the old stove to a "needy" family and will do this only through the nursing organization. When the agency itself makes exceptions, interpreting its function somewhat loosely as these illustrations indicate, it may be difficult for the field nurse to see at all where her boundaries lie in working with the staffs of other agencies.*

It is equally true that social agencies in turn sometimes encroach on the function of the nurse and with as little awareness of the fact that they are doing so. If the nurse wants an indication of the reaction of the social worker to the sporadic relief giving of the nursing agency, she need only remember her own dismay on discovering that a patient has been given advice on health matters by a social worker in a family agency, although the situation more appropriately demanded the nurse's or even the physician's services.

Both nurse and social worker may be defensive in their dealings with each other because each is troubled about her own program, either because she is dissatisfied with the way it is being worked out in the community, or because the situation on which the program is based may be changing or developing rapidly. Nurse and social worker may each be in the process of studying function for herself as an individual or as the member of an agency or a professional group. Each may feel that it is necessary, even admirable, to be feeling her way toward the best possible development of her own function in a given community and may be glad to discuss the question in meetings or conferences with her own group, but she may be unwilling to present her thinking to someone in another field before it is clearly and definitely formulated. It seems to be undermining to the security of each group to let the other know that any part of the working out of its function or policy is still very much in process.

It may be difficult for social workers in a given community to understand why the nursing program is so organized that the visiting nurses' work with infants ceases at preschool age; that the health supervision of these children is then taken over by a city nursing organization until they reach school age; but that when at this time health supervision is shifted to the school health



service, children requiring bedside nursing are returned to the care of the visiting nurse association. Although the health organizations in this community may be equally baffled and handicapped by such a setup, the chances are that they will defend it to the social worker as inevitable and even as workable rather than admit the difficulties resulting from such specialization and the probable fact that the health organizations are working to improve the situation.

Similarly, a social worker in this same community may not explain to the public health nurse that as a member of a "private" family agency she has adjusted her service to the fact that the greatly enlarged "public" agency has taken over much of the relief giving which formerly had been part of her responsibility. She may not make it clear to the nurse what it is that she as a family worker then finds to do in families that continue to seek her help — that there is much to be done but that she at times is still feeling her way toward a realignment of her function. Perhaps the social worker projects onto the nurse some of her own occasional desire to be "doing" more for the client, thus increasing her feeling that the nurse who is always "up and doing" would not understand the services her organization now is offering.

The upshot of this lack of communication between agencies and between agency workers may be that the public health nurse and the social worker in a certain community may not understand the phase of development of each other's organization. Therefore the current policies of the agencies are similarly misunderstood.

A comparatively small part of another agency's program may be mistaken for its whole purpose. Each professional group, while admitting the fallacy of judging its own work on the basis of immediate goals, falls into the trap of evaluating the other's achievement in a given situation on this basis.

The matter of relief giving as an organized, professional activity can be used here as illustration. Theoretically, public health nurses know that much thinking is being done about methods of giving relief and that immediate meeting of a family's material needs, as far as the family agency can do so, may not be the entire answer to the family's difficulties. Yet, practically, many of our referrals of families to family casework agencies do not even now show this awareness. Comment by family agencies on the type of case referred and the method of referral by public health nursing

agencies is too general to be disregarded. Part of our difficulty again is due to the fact that in some instances we have not learned to express clearly, either in writing or in discussion with the family agency, the problems we may see in a given family. Or perhaps the trouble is that we may continue to think of an immediate goal such as relief as *the* function, rather than as part of the function, of the family agency.

Similarly, members of the social work group may continue to confine the function of the nurse to bedside nursing and "advice" to mothers, and further, to limited methods of work in these activities—methods which do not see beyond the immediate patient to additional family problems or to existing attitudes and relationships. Theoretically, the social worker concedes a larger function to the nurse; actually, sometimes unconsciously, she may not do so. Her attitude may be revealed by the manner in which she sometimes makes her referrals to the nursing agency or by her failure to do so, or by her failure to show a desire to work in any really cooperative way with the nurse. She may merely "send the nurse in" to a given family.

All the considerations that have been touched on, namely, joint planning, mutual understanding of function, consciousness of one's own difficulties, are needed when nurse and social worker attempt to work cooperatively with the same family.

#### INTERAGENCY ASPECTS OF THE RELATION WITH THE FAMILY

If a situation that has been referred by the nurse is accepted for service by the family agency, the nurse may then have the task of thinking through the problem of how she can withdraw. This involves a willingness on her part to retire from a situation that perhaps has interested her greatly and in which she feels she has a professional stake. This withdrawal from what may have been quite intensive work with a certain family involves a technique in which the nurse may not feel at ease. She may pave the way for the social worker's entrance with intuitive or acquired skill. On the other hand, even when she is not hampered by a feeling of possessiveness where the family is concerned, the nurse may not know how to meet their reluctance to part from her and to enter upon a relationship with a new person.

It would be quite understandable if under these circumstances the nurse should respond to the family on a personal rather than a professional basis, without realizing that she is doing so because this is an exigency that her professional training may not have equipped her to meet. She cannot help being pleased that the family is devoted to her; she may be conscious of a flicker of satisfaction when they say that they do not like the social worker so well. She may be sorry for the sense of loss her absence is causing and may think that she must attempt to reassure the family by promises of casual visits. She may feel uncomfortable because she herself cannot do all that needs to be done.

These are natural reactions. Our training has not always given us what was described in a quotation in Part I of this chapter as one of the three kinds of equipment for social case work — "the controlled use of the capacity to relate oneself and one's service to people in need." This equipment seems as essential for the nurse as for the social worker. It may be a somewhat new experience for the nurse to attempt to think what it is that she as an individual means to her patient and to use this knowledge deliberately. In this particular situation the nurse recognizes that the family value her as an individual. While personally she may be glad they like her, she may also use this fact professionally. She cannot sever her connection with the family suddenly because of the strength of their feeling for her, but must prepare them for the fact that her function cannot take her much further with them. Because of their liking for her she can help the family to feel at home with the new worker. If one agency representative is acceptable to the family, the worker from another agency has, by the process of identification, a better chance of being really accepted. The nurse helps to bring this about not by emphasizing the personal qualities of the other worker, such as her ability to "understand" and her pleasant personality, but by explaining her function and by consistently and definitely directing the family to her when their requests and problems are not within the function of the nurse.

The nurse does not develop an intensive relationship such as the one just described with all her patients. Still, the way in which she takes leave of a family that she has attempted to interest in the work of a family agency and her method of withdrawal when her services are to be replaced by those of another nurse are techniques that warrant our attention.

In cases that are carried jointly, unless nurse and worker are in accord, the patient will find it easy and perhaps satisfying to criticize each worker and each agency program to the other, with the result that neither is really valuable to the patient. If nurse and social worker obviously respect each other's function, it is logical that the patient will respect both their functions.

Mutual understanding and respect also lessen the chance that either nurse or social worker will consent to act as go-between for the patient. For example, a certain family has been given partial aid by a social casework agency over a period of nearly a year. The mother is not well, there are small children who are given a poor diet, and the situation as a whole requires the continued work of the nurse. In fact, the mother has become quite dependent upon the nurse, who at first mistook this dependence for an interest in health matters. Apparently it is quite true that this family needs more blankets, clothes, and fuel. The mother tells the nurse that the worker from the family agency has not called upon her. Since the family has no telephone, the mother requests the nurse to ask the worker for needed supplies. This the nurse does on a number of occasions. Finally in a case conference it becomes clear that the family never have been willing to meet the family agency halfway. The father runs a small business, but beyond saying that he is losing money he is unwilling to discuss with the social worker the amount he actually loses — or very possibly makes — so that she can establish some basis for supplementary aid and for other work with the family. In other words, either this family do not understand the function of the family agency, or else they do not really desire any thoroughgoing relationship with it. In either case, by acting as a go-between instead of explaining the purpose of the family agency or suggesting that the family take their request directly to that agency, the nurse has postponed the possibility that family and worker will get together. However, nurse and social worker often do achieve a productive working relationship. Illustrations of success have been given in some detail in previous chapters.

#### INTERAGENCY CONFERENCES

In the earlier edition of this book, several pages were given to a discussion of the nurse's difficulty in participating comfortably

and well in interagency conferences. The statement was made that schools of nursing and also graduate courses still failed to prepare the nurse to express herself easily and helpfully in these conferences, while members of some of the other professional groups did have such training. Sometimes the nurse had, or occasionally still has, difficulty in preparing material for a case conference. That she may have considered these conferences as a procedure for the social worker rather than as one of her own tools was indicated by the nature of the material she sometimes assembled for presentation. Sometimes she may have prepared and offered generalizations about family attitudes and relationships when she could have contributed accurate details about the physical condition of members of the family and about attitudes centering on health or illness; often she could have given a valuable developmental history of the children. She did not always realize how gratefully such pertinent facts, dates, and observed conditions would be received by a conference group that was struggling for a reliable foundation on which to base conclusions. Realization of this would have given her, sooner than was the case, the security of true participation.

This is an area in which we seem to have made rapid progress, for which we can give credit both to better education in the conference method and to increasingly good use of it in public health nursing agencies. The spread of knowledge and skill concerning group methods in general has also helped us. One knows of no more important skill in this day and age when we cannot avoid continuous cooperation with others even if we wish to do so. We shall make further and more rapid progress in our ability to use and contribute to the conference as our knowledge of the dynamics of human behavior becomes more a part of us. We will then be able to see more readily how these factors affect the situation under discussion, and how they affect those around the conference table.

Far as community agencies have progressed in being able to work together, most of us would agree that working relationships among staff members still could be improved. The continued translation of function into coordinated service depends on the development of such relationships and on the efforts of directors,

supervisory staffs, and lay committees to establish workable policies. Mistaken administrative policies can block useful professional relationships. It seems clear, for example, that the workers in one professional group could not logically be employed to "supervise" the daily work of members of another professional group, though consultation might be appropriate. Much of the continuing improvement in interagency relationships depends, as far as the public health nurse is concerned, on an understanding of her own function and of the functions of other community agencies together with preparation for and means of communication with other agencies. The nurse uses her convictions about agency function with flexibility in order that she may be aware of, may study, and may eventually accept such constructive changes in professional purpose and method as are revealed by the needs of society and by improved research methods.

Here again one sees that attitudes and relationships do not exist by and of themselves, but that they arise from and contribute to the stage of development of our knowledge, skill, and individual characteristics.

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